2305 E Arapahoe Rd, Suite 250, Centennial, CO 80122
www.RMCDTherapies.com
Dr. Dwyer: 720-441-4858, Dr. O'Donnell: 720-295-4703, Fax: 720-398-3121

NEW PATIENT INTAKE PAPERWORK

Thank you for choosing to work with the professionals at Rocky Mountain Center for Development, LLC (RMCD). Our mission is to provide high quality, comprehensive behavioral health and educational support services for people of all ages. We work as a collaborative team of professionals to meet the needs of the whole person. We'd like to explain some important aspects of how our center works. Please review this form carefully and feel free to discuss it with your service provider.

RMCD employs and contracts with a variety of professionals in order to provide collaborative care. While you may not meet with multiple providers within our center, you will benefit from our shared knowledge. We discuss cases through multi-disciplinary collaborative meetings, and, of course, all providers treat information shared confidentially in accordance with the ethical guidelines of his or her profession.

As appropriate, you or your child may be referred to another professional within RMCD. A strong motivating factor for designing our center was to provide ease of service delivery and navigation for families, as well as for ease of sharing of information amongst multiple professionals working with an individual. We believe this arrangement is to your advantage for these reasons. Of course, you are always welcome to seek services outside of our center, and we will help you find appropriate referrals should you chose to do so for any reason. Professionals associated with RMCD are employees of or contractors of the business. As such, RMCD and its principal owners benefit when clients chose to see RMCD service providers.

FEES: Because we provide a variety of services, fees will vary depending on the type of service received and the provider with whom you work. We will always review fees with you prior to beginning any new assessment, treatment, or services. Fees and services discussed and anticipated for you/your child are as follows (*this will be completed in person with your provider*):

Type of Service	Fee per Unit	Payment Due Date	Notes

Please initial and date that you have reviewed and agreed to the above fees:_____

PAYMENTS: Fees are payable by check, cash, or credit/debit card (Visa, MasterCard, Discover) at each appointment. Our practice's policy is to securely store a form of payment on file for all of your sessions by credit/debit card. By doing so, we can avoid taking time away from your therapeutic work to check you in and process payment, and allow you to focus on the clinical work of our appointment. Each month you will receive an automated statement by email. Statements will show that you have paid for your services in full and are ready for you to forward to your insurance company should you wish to seek reimbursement. If you prefer to pay by check or cash, we kindly suggest that you have this ready to hand to your provider or the receptionist at the beginning of the appointment. Should you prefer to pay by credit card and/or do not present us with payment, your card on file will be automatically charged at the end of the appointment.

Appointments exceeding stated durations will be charged proportionately. Fees are typically raised around the first of the year; notice will be provided before a fee increase. If paying by check, you agree to pay any bank fees for returned checks, or $35 per returned check, whichever is more. If fees are not paid in full at the time of service, a $35 monthly billing charge will be added to your account. If billed charges are not paid and carry over to the next billing cycle, late fees of 10% of the prior month's balance will be added.

INSURANCE: Clients take full responsibility for seeking any reimbursements from insurance companies. RMCD neither directly bills insurance companies, nor accepts direct payments from insurance companies. An automated statement will be sent to the email you provide at the end of each month. Please be aware that not all services provided by our center are considered healthcare, and as such, many services are not eligible for reimbursement through insurance.

CANCELLED APPOINTMENTS: Cancellations must be made at least 24 business hours prior to your appointment or you will be charged the full fee for that session. If your appointment is scheduled on a Monday, notice must be given the Friday before your appointment to avoid being charged. Please be considerate of others who may be waiting for an appointment time and provide us with as much notice as possible should you need to reschedule an appointment so that we can provide that time to other clients.

ADDITIONAL FEES: You will be charged at an hourly rate for time incurred rounded up to 15 minute intervals for all services rendered outside of face-to-face appointment time, including but not limited to: letter and report writing, test interpretation, record review, collateral contacts, and travel time for services provided at any location away from our center. Phone calls and e-mails (reading and response) to you or on your behalf lasting more than a brief time will also be charged. Court appearances or other forensic activities and travel time associated with forensic activities will be billed at a higher rate due to the preparations involved. This will be discussed should the need arise.

USE OF COLLECTIONS: By signing this agreement, you agree that if necessary your account balance will be forwarded to a collection agency and you will be responsible for costs associated with collection, including attorney's fees, charges by the collection agency, and reimbursement of RMCD's time used during the collection activity, in addition to the amount owed. Your signature below grants RMCD permission to disclose necessary information to a collection agency should the need arise.

FAILURE TO KEEP APPOINTMENTS/PROVIDE PAYMENT: If you do not call to cancel and fail to show for your appointment more than one time during the course of treatment, or if you do not keep your account at a zero balance, you are giving the impression that you are no longer interested in services. Unless other arrangements are made, your case will be closed. Should this occur, we will be happy to provide you with the names of other service providers in the community.

HOURS OF SERVICE: RMCD operates by appointment only. Our telephone line allows for voicemails to be left 24 hours a day and messages are checked during working hours only. There is not emergency service available through RMCD. If you have a life-threatening emergency, you are advised to call 911 or to go to your closest hospital emergency room. If you feel you need therapeutic services with 24-hour availability, please let us know and we can refer you to an appropriate provider. Text messaging is not considered an appropriate way to contact us to cancel an appointment or for emergency issues—please call us instead.

INTERNET BASED COMMUNICATIONS: The confidentiality of disclosures made by internet cannot be ensured. The use of email is at the client's own risk and RMCD cannot be held responsible for any loss of confidentiality. Engaging in email contact with our office shows de facto consent and that the client assumes any risks of loss of confidentiality due to internet based communication.

TERMINATION: It is your right to terminate services at any time and for any reason. If you chose to end treatment, we will work with you to make this a positive experience. Providing us of advance notice will help us to appropriately wrap up our work with you, but even without advance notice we will support you in your choice and work with you on termination. Should you desire a referral to another professional, RMCD will provide you with one. If we feel that services must be terminated for whatever reason, we will provide you with advance notice whenever possible and with appropriate referrals.

Thank you for working with us. We look forward to helping you reach your goals. By signing below, you indicate that you agree to the above conditions of services and financial arrangements:

Printed Name of Service Recipient:_____

Signature of Service Recipient or Parent/Guardian:_____ Date: _____

Reviewed by RMCD representative:_____ Date: _____

New Patient Registration

Patient Name_____ Date of Birth_____ Marital Status_____

Mailing
Address_____

Home Phone_____ Work Phone_____ Cell Phone_____
Please note any confidentiality concerns with regards to leaving messages at above numbers:
_____

If patient is a child: Mother's Name_____ Father's Name_____

Best phone number at which to contact each parent: Mother_____ Father_____

Parents' Marital Status:_____ Child lives with:_____

Child's School_____ School Phone_____

Physician's Name_____ Phone_____

Emergency Contact:_____ Phone_____

Person Financially Responsible:_____ SS#_____

Employer_____ Employer's Address _____

Email address to send statements and/or appointment reminders:_____
(We will send this email address an authentication email—statements will not be delivered until the email address is authenticated by you.)

List names and date of birth of all persons living with patient, as well as relationship to patient:
_____
_____
_____
_____

Referred by:_____ May we contact them to thank them for the referral?_____
Please note any scheduling preferences:

Please note billing preferences (pay by check/cash or use credit card on file): _____

Patient (or guardian) signature_____ Date_____
RMCD Representative Signature_____ Date_____

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through RMCD. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Client Information:

Client Name: _____ Date of Birth: _____

Billing Information: Please indicate the information associated with the debit card you wish to use.

_____(check) I prefer to use a credit card.

Name:

_____

Address: _____ City_____ State: _____

Zip: _____Email:_____

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

Please enter the CVV code _____ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s): _____

I understand that this form authorizes my provider to charge this card for varying session types (including no shows/late cancellations), across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Cardholder Signature Date

Payments are processed by Therapy Partner. Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

(To be removed and shredded by RMCD after information is stored securely in payment software)

Debit Card Information: _____(check) I prefer to use a credit card.

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

ROCKY MOUNTAIN CENTER FOR DEVELOPMENT, LLC: DISCLOSURE STATEMENT

1. This disclosure statement pertains to the mental health professionals providing services either as employees or contractors of RMCD.

2. The following describes the credentials of each mental health professional employed by RMCD at the time the below signed patient initiated treatment:

   Dr. Kimberly Dwyer holds the following degrees, licenses, and credentials:
   - Degrees: B.A., Fairfield University, CT; M.S. & Ph.D., Nova Southeastern University, FL
   - Licenses, Credentials, Registrations, and Certifications: State of Colorado, Licensed Psychologist #2530

   Dr. Colleen O'Donnell holds the following degrees, licenses, and credentials:
   - Degrees: B.A., University of Kentucky; M.A. University of Dayton, OH; Ph.D., University of California, Berkeley
   - Licenses, Credentials, Registrations, and Certifications: State of Colorado, Licensed Psychologist #4380; State of California, Licensed Educational Psychologist, License #3360 (inactive)

   Dr. Yvonne DelZenero holds the following degrees, licenses, and credentials:
   - Degrees: B.S., Drake University, IA; M.A. Loyola University, IL; Ph.D. Palo Alto University, CA
   - Licenses, Credentials, Registrations, and Certifications: State of Colorado, Licensed Psychologist #4715

   Ms. Cecilia Kosak holds the following degrees, licenses, and credentials:
   - M.A. In Marriage and Family Therapy and Clinical Art Therapy: Loyola Marymount University, Los Angeles, CA
   - B.A. In fine arts and psychology: University of Colorado, Boulder
   - Licenses, Credentials, Registrations and Certifications: Licensed Marriage and Family Therapist: MFT.0001059, Registered Art Therapist: 10-192, certified in Trauma Focused Cognitive Behavioral Therapy (TFCBT)

3. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychological Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303-894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training, or experience is required.

4. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

5. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

6. Any person who alleges that a mental health professional has violated the licensing laws 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 wihtin seven years after the prson discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.

7. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Mental Health Statute, as well as other exceptions in Colorado and Federal Law. For example, mental health professionals are required to report child abuse to authorities. Confidentiality may additionally be broken due to threat of suicide or homicide. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

I have read the preceding information, and I understand my rights as a client or as the client's responsible party. If I am a parent/guardian signing for a minor client, I attest that I have the legal rights to consent to treatment for this child.

Patient Name:_____Patient/Guardian Signature_____ Date_____

RMCD Representative_____ Date_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:_____ DOB:_____

Regarding the above named Patient, I_____ authorize any and all employees/contractors at Rocky Mountain Center for Development at the above listed address to release_____ exchange_____ protected health and/or educational information with:

_____
(name of person/facility and address to receive information)

Please specify the health information you authorize to be released:
Medical_____ Mental Health_____ Other_____
Type(s) of health information:_____
Date(s) of treatment:_____

The purpose of this release is (check one or more):
At the request of patient/guardian._____ Other (state reason):_____

NOTICE
Rocky Mountain Center for Development, LLC, and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS
This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) To conduct research-related treatments, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Rocky Mountain Center For Development, LLC. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires on _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months from date of signing this form.

Printed Name of Patient/Guardian:_____
Signature of Patient/Guardian:_____ Date_____

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AUTHORIZATION FOR RELEASE OF INFORMATION—Continuity of Care

Name of Patient:_____ DOB:_____

In an effort to provide continuity of care, Rocky Mountain Center for Development will share updates on therapy and/or copies of evaluation results with other professionals at your request.

Regarding the above named Patient, I_____ authorize any and all employees/contractors at Rocky Mountain Center for Development at the above listed address to release protected health and/or educational information with (please provide names of individuals and addresses to receive information):

Referral Source: _____

Physician:_____

School:_____

Tutor:_____

Specialist (Therapist, Psychiatrist, Other providers):_____

Please specify the health information you authorize to be released:
Medical:_____ Mental Health:_____ Educational: _____
Any and all:_____

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EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this authorization expires 12 months from date of signing this form.

Printed Name of Patient/Guardian:_____
Signature of Patient/Guardian:_____ Date_____