Beverly Hawpe and Associates

Consent for Use and Disclosure of Health Information

Section A: Giving Consent

Name:_____

Address:_____

Telephone:_____ Social Security Number:_____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations and the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in or Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will highlight the changes. Those changes may apply to some or all of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Beverly Hawpe
724 North Tejon Street
Colorado Springs, CO 80903
Telephone: 719-227-7745
Fax: 719-227-7743

Right to Revoke: You will have the right to revoke this Consent at any time by providing written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation. We may decline to treat you or continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to you to use and disclose my protected health information to carry out treatment payment activities and health care operations.

_____

Signature Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

DACODS Reporting System

All facilities licensed by the state of Colorado are required to report demographic and treatment episode information into the state DACODS reporting system for tracking and statistical purposes. If you do not want your information reported through this system, please sign below option 2.

Option 1

I do not object to my information being included in this reporting system.

_____ _____

Signature Date

Option 2

I object to my personal information being included in this reporting system.

_____ _____

Signature Date

Beverly Hawpe and Associates

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, _____(print name), have received a copy of this office's Notice of Privacy Practices.

_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but we were unable to do so because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited us from obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other:_____

Beverly Hawpe and Associates
Statement of Understanding

Private Practice Therapist – Beverly Hawpe is a Licensed Professional Counselor that offers assessment and treatment to Insured.

Fees – Assessment/treatment sessions are provided at the contracted rate. Failed appointment charges ($100.00) are your responsibility (i.e. failure to give 24 hour notice). Reimbursement for services by your insurance company is not guaranteed and is subject to the terms of your contract with them. Please check with your company's benefit staff and/or insurance company if you have questions about your coverage. Co-payments are due at the time of service.

Confidentiality – No one will reveal information concerning your treatment to anyone outside of our program except as follows: 1. you consent in writing; 2. life or safety is seriously threatened; 3. claims payer requires information.

I, _____(print name), understand this form and accept it as the terms of my use of services.

_____

Signature Date

_____

Parent/Legal Guardian Date

_____

Witness Date

PAYMENT AGREEMENT

The following services are offered by Beverly Hawpe, LPC, LAC:

- $110.00 Initial Appointment Fee
- $100.00 Individual Therapy Fee
- $110.00 Family / Couple Therapy Fee
- $50.00 Missed Appointment Fee
- $55.00 Group Therapy Fee
- $500.00 Evaluations (Divorce/Custody)
- Evaluations: Substance Abuse $300.00
  Mental Health $400.00
  SA/MH $450.00
  In Custody Evaluations Add $100.00
- $150.00 Juvenile Diversion Evaluation
- $5.00 Breathalyzer
- $25.00 Urinalysis / $35.00 ETG / $115.00 PETH
- $90.00 Hair Follicle Test
- $50.00 Medication Monitoring Fee
- Court Testimony: $500.00 / First Hour
  $250.00 / Each Additional Hour
- Court Preparation: $80.00 / Per Hour
- Telephone Consult: $80.00 / Per Hour
- Record Review: $40.00 / Per Hour
- $140.00 Office Emergency
- $14.00 Copy Fee (up to 10 pages - .25 each additional page)
- $30.00 Returned Check Fee

Beverly Hawpe will bill the insurance company for services rendered at the above rates as a courtesy to the client. Insurance companies do not guarantee payment for services; therefore, the guarantor is responsible for all charges incurred. PAYMENT IS DUE AT THE TIME OF SERVICE. This includes all deductibles; co-pays, and co-insurance. Most insurance companies require pre-authorization for services. All benefits must be verified.

I have read and understand the terms of this payment agreement. I hereby sign this agreement with full knowledge of the terms listed above. I give Beverly Hawpe permission to send out any information necessary to process my account for payment of services rendered. I understand that failure to comply with this payment agreement is grounds for my account to be sent to a collection agency and for late fees (1.5% rate per month) to be added to my account. I understand that I will be responsible for all legal and collection fees associated with my account if it goes into a delinquent status.

Client Name:_____ Date:_____

Guarantor Signature:_____ Date:_____

Witness Signature:_____

Beverly Hawpe and Associates
Insurance Declaration

I, _____, do hereby confirm that I

do_____/do not_____ have a secondary insurance company.

Primary Insurance Company_____

ID #_____ Group #_____

Policy Holder Name_____

Secondary Insurance Company_____

ID #_____ Group #_____

Policy Holder Name_____

_____ _____

Policy Holder Signature Date