OPEN DOOR COUNSELING CENTER

Diana Powell-Lawrence LPC,CACIII

Consent for Tele Health Mental Health Therapy

Client Name:_____

This consent will explain the nature of counseling through Tele Health services. Therapy will be conducted through technology assisted media, IE phone, smart phone, tablet, PC, desktop or other electronic means. My therapeutic services will come through "Zoom" which is a HIPPA compliant site.

From your end please protect your own confidentially ,finding a quite secure place while we meet.

Your records remain in a safe secure setting as per the state governing board of Colorado .

If a co pay is owed you can either send to my office address at 7222 Commerce Center Dr #132 CSC 80919 or through the video session you can give me credit card number and I will run through square.

Client Signature_____ Date:_____

Therapist Signature_____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Diana Powell-Lawrence LPC CACIII
Open Door Counseling Center PC
Phone 719-229-9811

Name_____

DOB_____

Address_____

City/zip_____

Phone_____

Email_____

Employer_____

Marital Statue : Single Married Partnership Divorced Separated Widowed

Emergency Contact_____

_____

Medications :

Name and dosage:

_____ _____

_____ _____

_____ _____

_____

Reason for appointment
today_____

_____

Diana Powell-Lawrence LPC CACIII
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Phone 719-229-9811

What do you want to accomplish in therapy

Disclosure Statement

Qualifications and Experience:

I have completed my Masters in Counseling through Colorado Christian University. I have completed my BA in both Psychology and Sociology at the University of Colorado at Colorado Springs. I am registered at the state of Colorado as both a Licensed Professional Counselor and certified Addictions Counselor Level III. I have been trained as a Level II EMDR therapist.

Nature of Counseling:

Session can become both emotional and psychological, it is important to realize our relationship is a professional one. Our contact will limited to sessions. It is my desire to help you move forward towards your goals and resolve the problems that brought into counseling.

Regulations:

The Colorado Department of Regulatory Agencies has general responsibilities to regulating the practice of licensed psychologist, licensed social workers, licensed professional counselors , licensed marriage and family therapist , licensed school psychologist practicing outside the school setting, and unlicensed individuals who practice psychotherapy. The agency within the Department has the responsibility for licensed and unlicensed psychotherapist is the Department of Regulatory Agencies, Mental health section, 1560 Broadway, suite 1350, Denver Co. 80202, 1-303-894-7766. You can visit the site at hhttp:www.dora.state.co.us.

Clients Rights:

1. You are entitled to receive information from me about my methods of therapy, techniques I use and the duration of your therapy. (if it can be determined)

2. You have the right to a second opinion from another therapist at any time.

3. Generally speaking information provided by client during therapy session is legally confidential , therefore the therapist can't release information without the clients consent.

There are exceptions to the general rule of legal confidentially . These exceptions are listed in the Colorado statues (C.R.S.12-43-218). You should be aware that

provisions concerning disclosure of confidential communications shall not apply to any criminal or delinquency or criminal proceeding , except provided y section 13-90-107C.R.S. There are exceptions that I will identify to you as the situation arises during therapy.

Records:
All communication become apart of the clinical record , and is assessable to you upon request.
By you signature below, you are indicating that you have read the preceding information and you understand this statement, and /or that any questions you have about this statement have been answered to your satisfaction

.

_____ _____

Client/ Parent **date**

_____ _____

Therapist Diana Powell-Lawrence **date**

Diana Powell-Lawrence Ma, LPC, CACIII

I client/Parent/ Guardian agree to receive therapeutic treatment from Diana Powell-Lawrence LPC, CACIII. I understand this is a voluntary relationship and am free to terminate at any time. I understand that what happens in therapy stays in therapy unless myself/child makes a threat to harm self or others. My therapeutic records can be releases under a court order as well.

_____ _____

Client/ Parent Legal Guardian Date

Diana Powell-Lawrence LPC, CACIII LLC

Client Billing Agreement

1. I understand I am responsible for co- pay at every session.
2. I understand that if I have not met my deductable then I am responsible to pay at time of service until the deductible is met.
3. If I am a cash client I understand I am responsible to pay the day of service.
4. I understand that Diana Powell-Lawrence LPC will file claims with my insurance company and I am responsible for any further needed information
5. I authorize release of billing information to Diana Powell-Lawrence and any billing service that she uses.
6. If account falls delinquent and must turn over to collection I authorize release of any needed information to facilitate the collections process.
7. I understand that I have to pay an $90.00 fee for any no show or late cancel less than 24 hours.
8. Sessions are 45 to 50 minutes long.
9. I understand I am contracting for services with Diana Powell_Lawrence LPC for the purpose of therapy.

Client/ Legal Guardian/Parent Signature

Date

Client Name