INTAKE PACKET

Questions? **EMAIL** mhp@milehighpsychiatry.com

Scheduling Preferences

Why would you like to be seen:

Are there any specific aspects of your provider's background or experience that are important to you?

Is there anything else that you would like us to know?

How did you hear about us?

Please list your availability for appointments:

Day of Week	Availability
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Identification

Legal First Name

Legal Last Name

Preferred Name

Date of Birth

Legal Sex

SSN (Required for Medicare only

INTAKE PACKET

Contact Information

Mobile Phone:

Home Phone:

Work Phone:

Patient Email:

Address:

City:

State:

ZIP Code:

Consent to Receive Calls: ☐ Yes ☐ No

Consent to Receive Texts: ☐ Yes ☐ No

Emergency Contact

Emergency Contact Name:

Emergency Contact Relationship:

Emergency Contact Phone #:

Optional Demographics

Language:

Race:

Ethnicity:

Marital Status:

Gender Identity:

Pronouns:

How did you hear about us:

INTAKE PACKET

Payment

Primary Insurance Plan:

Primary Member ID:

Secondary Insurance Plan:

Secondary Member ID:

Preferred Pharmacy Name and Address

Guarantor (name to whom statements are sent - SKIP IF SELF)

Patient's relationship to gurantor:

First Name:

Last Name:

Middle Name:

DOB

Mailing Address: ☐ *Guarantor's address same as patient*

City:

State:

ZIP Code:

Consent for Treatment

Thank you for selecting Mile High Psychiatry LLC (MHP) for your mental health needs. We value the trust you place in us and are committed to providing personalized care to you and your loved ones. MHP wants individuals to understand their rights and responsibilities as patients of MHP. Your signature on this document signifies your Consent for treatment, Assignment of Benefits, Medication History Authorization, Payments, Fees, Insurance and Release of Billing Information and acknowledgment of our practice policies and Notice of Privacy Practices. Should you have any inquiries about our policies, please don't hesitate to reach out to us at **(720) 507-4779**. Our full documents are linked to this document and can be viewed at any time at milehighpsychiatry.com/patient-resources/ Print out versions can be mailed upon request.

Consent for treatment

- I authorize the attending physician, physician's assistant, referring providers, and other members of the healthcare team to perform necessary examinations, treatments, diagnostic testing, transfers, and transportation, both in-person and via telehealth, as deemed medically necessary.

Assignment of Benefits:

- I authorize my benefits to be assigned to MHP for healthcare services as detailed in MHP's Assignment of Benefits document.

Medication History Authorization:

- I authorize MHP to collect and review my medication history as detailed in MHP's Medication History Authorization document.

Payments, Fees, Insurance and Release of Billing Information:

I understand and agree to the policies provided in MHP's Payments, Fees, Insurance and Release of Billing Information including but not limited to:

- Payments are due at the time of service unless other arrangements have been made.
- For your initial evaluation, lasting approximately 40 to 60 minutes, our standard fee is $285.
- Follow-up sessions usually last between 21 to 40 minutes and involve either therapy alone or a combination of therapy and medication management. The cost for these sessions is $175.
- Depending on your specific treatment plan, additional services may be necessary. These extra services can add up to an additional $100.

Patient Responsibilities:

I understand and agree to the policies provided in MHP's Patient Responsibilities including but not limited to:

- If you must cancel or reschedule an appointment, we require at least 24 hour notice (weekends not included).
- Cancellations that occur with less than 24 hour notice or if you fail to show up to an appointment, will incur a no-show fee as outlined in the full Patient Responsibilities document.
- If there is a negative balance that is owed, the balance must be paid prior to or at the time of the next visit.
- I understand that I must be a resident of the State of Colorado to be eligible for Tele-Psychiatry services from my provider.
- I will not record any Tele-Psychiatry sessions without written consent from my provider.

Prescription Policy:

I understand and agree to the policies provided in MHP's Patient Responsibilities including but not limited to:

- MHP requires 3 business days minimum to process prescription(s) renewals/requests. Patients are responsible for knowing when medication(s) will need to be refilled. No early refills will be accepted.
- Prescriptions will not be refilled on Saturday, Sunday or major holidays. Prescriptions will not be filled on a "walk-in" basis.
- Random and/or regular lab testing via blood or urine is required from all MHP patients to ensure patient safety and proper patient care.
- NO controlled substances or stimulants will be provided as "bridge" scripts. Patients are required to keep scheduled medication management appointments in order to receive refills for medications.

Notice of Privacy Practices:

- I acknowledge and agree to MHP's "Notice of Privacy Practices."

By signing below, you certify that you have read and understand the terms as stated in the Consent for treatment, Assignment of Benefits, Medication History Authorization, Payments, Fees, Insurance and Release of Billing Information, Patient Responsibilities, Prescription Policy, and Notice of Privacy Practices. You Indicated that you understand the scope of our services, session structure, fees, cancellation and no show policies, payment policy, insurance reimbursement, confidentiality, the nature of our practice, our contact information and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client Name (Printed): _____

Client Signature: _____ Date:_____

Parent/Guardian Signature *(If applicable)*: _____ Date:_____

Mile High Psychiatry, Corporate Offices
2675 S Abilene St #100
Aurora, CO 80014
Phone: 720-507-4779

Mile High Psychiatry, LLC
Mandatory Disclosure and Therapeutic Policies Form

This document outlines the policies, procedures, and rights associated with therapy services provided by Mile High Psychiatry, LLC. It is compliant with the Health Insurance Portability and Accountability Act (HIPAA) and applicable Colorado statutes and federal regulations.

Therapist Contact Information

- **Location:** Mile High Psychiatry operates remotely and has physical offices at 14221 E. 4th Avenue Ste. 2-126, Aurora, CO 80011 and 2675 S. Abilene St. Ste. 100, Aurora CO 80014
- **Phone**: (720) 507-4779
- **Company Email**: mhp@milehighpsychiatry.com

Therapists and Credentials:

The following therapist works remote for Mile High Psychiatry, LLC and provides behavioral health services via a secure telemedicine platform:

Manuel J. Molina, LPC-S of Mile High Psychiatry, LLC. Manuel Molina earned a Masters in Counseling from Sam Houston State. He is a Licensed Professional Counselor- Supervisor in the state of Colorado. (LPC.0017057)

Manuel J. Molina: I am a Licensed Professional Counselor-Supervisor, listed in the Colorado database, and thereby authorized to practice psychotherapy. I am a licensed psychotherapist and I am required to satisfy any standardized educational or testing requirements to obtain registration in Colorado.

The following therapist works remote for Mile High Psychiatry, LLC and provides behavioral health services via a secure telemedicine platform:

Molly Rust, LPCC of Mile High Psychiatry, LLC. Molly Rust earned a Masters of Arts in International Disaster Psychology from the University of Denver. She is a Licensed Professional Counselor Candidate in the state of Colorado. (LPCC.0021362)

Molly Rust: I am a Licensed Professional Counselor Candidate, listed in the Colorado database, and thereby authorized to practice psychotherapy. I am a licensed psychotherapist and I am required to satisfy any standardized educational or testing requirements to obtain registration in Colorado.

Mile High Psychiatry, Corporate Offices
2675 S Abilene St #100
Aurora, CO 80014
Phone: 720-507-4779

Katerina Casas, LPC of Mile High Psychiatry, LLC. Katerina Casas earned a Masters of School Counseling from Capella University. She is a Licensed Professional Counselor in the state of Colorado. (LPC.0019502)

Katerina Casas: I, Katerina Casas, am a Licensed Professional Counselor, listed in the Colorado database and thereby authorized to practice psychotherapy.I am a licensed psychotherapist and am required to satisfy standardized educational or testing requirements to obtain registration in Colorado.

Anastasia Homer, LPCC of Mile High Psychiatry, LLC. Anastasia Homer earned a Masters of Counseling from Post University. She is a Licensed Professional Counselor Candidate in the state of Colorado. (LPCC.0023392)

Anastasia Homer: I, Anastasia Homer, am a Licensed Professional Counselor Candidate, listed in the Colorado database and thereby authorized to practice psychotherapy.I am a licensed psychotherapist and am required to satisfy standardized educational or testing requirements to obtain registration in Colorado

---

Patient Consent Requirements

- Individuals 12 Years and Older: All patients aged 12 years or older residing in Colorado must sign this disclosure statement.
- Minors Under 12 Years: A parent or legal guardian with the authority to consent to mental health services must sign this disclosure statement on behalf of their minor child under the age of 12.

Policies and Procedures

This disclosure statement outlines the policies and procedures of Mile High Psychiatry, LLC. No medical or psychotherapeutic information, or any other information related to your privacy, will be disclosed without your permission unless mandated by Colorado law or federal regulations. Relevant legal references include:

- Colorado Statutes: Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS.
- Federal Regulations: 42 C.F.R. Part 2 and HIPAA (45 C.F.R. Parts 142, 160, 162, and 164).

Documentation Requirements for Minors

- Required Documentation: Copies of current legal documents (e.g., divorce decrees, adoption decrees, conservator paperwork, custody agreements, court orders) must be provided to Mile High Psychiatry, LLC prior to treatment.

- Treatment Restriction: Treatment will not be provided to minors unless the necessary documents are submitted and reviewed.
- Record Keeping: Copies of these documents will be maintained in the minor's electronic health record.
- The parent or legal guardian authorized to consent to treatment must sign the consent form to authorize treatment for the minor.

Client Rights and Important Information

Client Rights

- Information on Therapy Methods: Clients are entitled to receive information about the methods of therapy, techniques used, the duration of therapy (if determinable), and the fee structure.
- Restrictions on Uses: Clients may request restrictions on certain uses and disclosures of protected health information per 45 CFR 164.522(a). However, Mile High Psychiatry, LLC is not required to agree to restriction requests.
- Second Opinion and Termination: Clients are entitled to seek a second opinion or terminate therapy at any time.

Sexual Intimacy

- Professional Boundaries: Sexual intimacy between a psychotherapist and a client is never appropriate and should be reported to the Colorado Department of Regulatory Agencies (DORA).

Confidentiality

- General Confidentiality: Information shared during therapy sessions is legally confidential unless disclosure is required by law.
- Exceptions to Confidentiality: Exceptions include:
    - Reporting child abuse or neglect.
    - Reporting abuse or exploitation of an at-risk elder or imminent risk of such abuse.
    - If the therapist determines a danger to self or others.
    - Compliance with court orders.
- Electronic Communication: While confidentiality extends to electronic communication, these methods cannot guarantee absolute security. Mile High Psychiatry uses encryption and other security measures.

Family and Couples Therapy

- Family or Couples as Clients: The couple or family is considered the client. Individual sessions may remain confidential unless disclosure is required by law or agreed upon.

Disclosure Regarding Divorce and Custody Litigation

Mile High Psychiatry, Corporate Offices
2675 S Abilene St #100
Aurora, CO 80014
Phone: 720-507-4779

- Therapists will not provide recommendations to the court concerning custody or parenting issues. By signing this disclosure, clients agree not to subpoena the therapist for court testimony or records.

Electronic Records

- Client information may be stored electronically on Mile High Psychiatry's secure systems, using firewalls, encryption, and remote-wipe capabilities.
- Records will be maintained in compliance with Colorado state laws in case of a therapist's death, incapacity, or termination.

Therapy Program Cancellation and Reschedule Policy

- Appointments require at least 24 hours' notice for cancellation. A $100 fee applies for late cancellations or no-shows, with exceptions for serious illness or extreme weather.

Patient Dismissal Policy

- Missing two consecutive appointments or multiple appointments within 30 days without proper notice may result in termination of services. Reopening a case may require placement on a waitlist.

Consent for Treatment

- Clients aged 12 and older in Colorado may consent to therapy services.
- Legal guardians must provide consent and relevant legal documentation for minors.

Group Therapy Rules and Procedures

- Participation Rules:
  - Respect confidentiality.
  - Avoid discussing private health information outside sessions.
  - Refrain from using drugs, alcohol, or offensive language during sessions.
  - Provide 24 hours' notice for cancellations.
- Violations may result in discharge from group therapy, with alternative resources provided.

Acknowledgment

By signing this form, I confirm that I understand the therapy services offered, my rights as a client, and my responsibilities. I have received a copy of this disclosure or declined a copy at this time.

Client Information

Mile High Psychiatry, Corporate Offices
2675 S Abilene St #100
Aurora, CO 80014
Phone: 720-507-4779

Client Printed Name: _____
Date: _____
Client Signature: _____

For Minors

Parent/Guardian Printed Name: _____
Date: _____
Parent/Guardian Signature: _____

Mile High Psychiatry, Corporate Offices
2675 S Abilene St #100
Aurora, CO 80014
Phone: 720-507-4779

Important Information for Medicare Patients: Collaborative Practitioner Form

As part of your intake paperwork, you'll find a Medicare Collaborative Practitioner form. This form helps us coordinate your care with your Primary Care Provider (PCP) and is required for certain Medicare-related services.

What You Need to Know:

Who needs this?
Patients who are enrolled in Medicare.

Why is it included?
To help facilitate communication between your PCP and our team for collaborative care and Medicare compliance.

What do I do with it?
This form allows you to have the option to have your PCP complete instead of commuting to one of our office locations.

What else is required?
An encounter note from the visit where the form was completed must also be submitted. This helps confirm that the form was discussed alongside your mental health needs, and filled out during a medical appointment.

How to Return the Form & Note:

By your PCP's office:
They can fax or securely email both the completed form and visit note directly to us.

By you:
If you receive the completed form and visit note, you may also fax or securely email them to our office.

Submission Options:
Digital Form
Fax: 833-941-5047
Secure Email: mhp@milehighpsychiatry.com

If you have questions about this form or how to complete it, our team is happy to help!

MHP
MILE HIGH PSYCHIATRY

Assignment of Benefits

I hereby authorize benefits to be assigned to Mile High Psychiatry LLC, ("Provider"), for healthcare services provided to me by Provider. I hereby certify that the insurance information that I have provided the Provider is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance may not pay 100% of the amount of the medical claim and I am responsible for payment of any and all amounts not paid by my insurance company within 90 days, including for any services which my insurance company has determined not to be covered by my policy. If a payment is 90 days past due, we reserve the right to utilize legal resources such as collection agencies or small claims courts in order to obtain payment for our services. If your account is submitted to a collection agency, a 40% collection fee will be added to your outstanding balance upon submission to the agency. By signing this form, you agree to this charge.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided the Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demands in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to Provider at **14221 E 4th Ave #2-126, Aurora, CO 800112**, for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Provider to be my personal representative, which allows Provider to: (1) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

Mile High Psychiatry, Corporate Offices
2675 S Abilene St #100
Aurora, CO 80014
Phone: 720-507-4779

Card on File Authorization

Patient Name:
Maximum Charge Amount: $1500
Effective Date: (Set to date of signature)
Expiration Date: (Set to one year from the Effective Date)

I agree to allow Mile High Psychiatry LLC (the "Practice") to charge my credit/debit card listed below (the "Payment Method") for any patient balance due (up to the Maximum Charge of $1500 per year), for all services provided by the Practice to the patient(s) listed on this Authorization on or after the Effective Date and before the Expiration Date. I acknowledge that:

I agree to allow Mile High Psychiatry LLC (the “Practice”) to charge my credit card listed below for any patient balance due (up to $1500.00/year), for all services or fees provided by the Practice to the patient listed on this Authorization on or after the Effective Date and before the Expiration Date.

Name on Card:
Card Number:

Expiration: **CVV:**

I acknowledge that:

- My Payment Method will only be charged for the remaining patient responsibility not paid by insurance, after insurance has been applied.
- I will receive a receipt for each payment detailing the amount charged.
- My Payment Method will be charged for services rendered to the Patient (listed above and any patient who - at the time of their charge drops - have combined billing and statements with the above patient
- My Payment Method information will be securely stored by the Practice and/or the Practice’s trusted service providers to facilitate collection of payments.
- I may cancel this Authorization at any time by contacting the Practice. If I cancel, the Practice will bill me directly for any patient responsibility, and I will be responsible for any such amounts.
- If I make any changes to this Card on File Authorization (e.g., by contacting the Practice or via online payment workflows powered by athenahealth, Inc.), such changes will supersede the details included in this Authorization and will automatically amend it.
- All information I have provided in connection with this Authorization is true and accurate. I certify that I am an authorized user of the Payment Method.

Authorized by:
Signature: Date Signed:

MHP
MILE HIGH PSYCHIATRY

HIPAA Privacy Release of Information Authorization Form

I hereby authorize and request to furnish the protected health information of:

Patient Name: _____ Patient DOB: _____
Social Security #:_____ Phone Number:_____
Address: _____ City: _____ State: _____

You may use or disclose the following health care information *(check all that apply)*:

❏ All my health information
❏ All my health information **except**:
  ❏ Mental Health Records
  ❏ Communicable Diseases (including HIV or AIDS)
  ❏ Alcohol/Drug abuse
  ❏ Lab Results
❏ Other: _____

I authorize for release of PHI covering the period of healthcare

❏ From (date) _____ to (date) _____
❏ All past, present, and future periods

Reason for this authorization:_____

This section is only applicable when records are being released from one organization/practice to another.

Release Records **FROM**:

Name:_____
Address:_____ City:_____ State: _____
Phone:_____ Fax:_____ Email: _____

Send Records **TO**:

Name:_____
Address:_____ City:_____ State: _____
Phone:_____ Fax:_____ Email: _____

I authorize disclosure of information regarding my billing, condition, treatment, and prognosis along with my PHI as I have selected above to the following individuals:

Name:_____ Phone:_____ Relationship:_____
Name:_____ Phone:_____ Relationship:_____
Name:_____ Phone:_____ Relationship:_____
Name:_____ Phone:_____ Relationship:_____

I have carefully read and understood the above, have had any questions answered to my satisfaction, and do hereby voluntarily authorize disclosure of the above information or medical records of my conditions to those persons or organizations listed above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law.

This release is effective until(Date) _____. I may revoke this release in writing at any time._____(Initials)

_____	_____	_____
Patient or Legally Authorized Representative Signature	Relationship to patient	Date

Medication History Authorization

I, the patient (or parent/guardian of the patient if applicable), hereby authorize Mile High Psychiatry, LLC, to collect and review my medication history. I understand that the adoption of an electronic medical record system by Mile High Psychiatry is intended to improve the quality of healthcare services and enhance patient safety.

A medication history is a compilation of prescription medicines that have been recently prescribed for me by Mile High Psychiatry or other healthcare providers. This information is obtained from various sources, including my pharmacy and health insurer.

I acknowledge that having an accurate medication history is crucial to ensure proper and safe medical treatment, as it helps in avoiding potentially dangerous drug interactions. By signing this consent form, I grant Mile High Psychiatry permission to collect and request my pharmacy and health plan to disclose information about my prescriptions, including prescription medicines used to treat mental health conditions such as depression, as well as medicines for other medical conditions, including those related to AIDS/HIV.

I understand that this medication history will become a part of my medical record at Mile High Psychiatry.

It is important to note that while the medication history is a valuable guide, it may not be entirely accurate. Some pharmacies may not provide drug history to Mile High Psychiatry, and certain medications that I purchased without using my health insurance may not be included in the drug history from my health plan. Additionally, over-the-counter medicines, supplements, or herbal remedies might not be captured in the medication history. Therefore, I recognize the importance of discussing all medications and supplements I am taking during my appointments with Mile High Psychiatry and pointing out any errors in my medication history.

I also give my explicit permission to Mile High Psychiatry to obtain my medication history from my pharmacy, health plans, and other healthcare providers for the purpose of ensuring comprehensive and well-informed healthcare services.

MHP
MILE HIGH PSYCHIATRY

Mile High Psychiatry LLC

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

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

Your Rights

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 medical record	• To request a copy of your medical records or to request a copy of your medical records be made available to any other health care provider, we require you to complete our HIPAA Release Form. A copy of the HIPAA Release Form can be found here. You may submit your completed HIPAA Release Form to mhp@milehighpsychiatry.com
Ask us to correct your medical 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.

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.

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 the back page. • 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.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us 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 us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to 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
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

Psychotherapy Notes

- Psychotherapy Notes are created for your treatment, we must obtain your prior written authorization, most recent identification, and verbal consent before using or disclosing them, except (1) if the creator of those notes needs to use or disclose them for treatment, (2) for use or disclosure in our own supervised training programs in mental health, or (3) for use or disclosure in connection with our defense of a proceeding brought by you. “Psychotherapy Notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. “Psychotherapy Notes” excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Note that if, in the sole discretion of your healthcare provider, providing you with copies of your Psychotherapy Notes could be harmful or detrimental, we have the right to deny your request for such records.

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Colorado Privacy Act (CPA) : The Colorado Privacy Act gives Colorado resident consumers five rights over their personal data.

-The right to opt out of the processing of personal data for targeted advertising purposes, the sale of their personal data, and automated profiling in furtherance of decisions that produce legal or similarly significant effects.
-The right to access their personal data held by a data controller.
-The right to make corrections to their personal data if inaccuracies are identified.
-The right to have their personal data deleted.
-The right to have their data provided in a portable and ready to use format.

For more information on this, please visit: https://coag.gov/resources/colorado-privacy-act/

You may also refer to our Privacy Policy for more information related to the collection of information that is not classified as personal health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to:

Mile High Psychiatry LLC

Corporate Address: 14221 E 4th Ave #2-126, Aurora, CO 80011

Website: https://milehighpsychiatry.com/

MHP Privacy Official: Calvin Beasley

Email: mhp@milehighpsychiatry.com

Phone: (720) 507-4779

Effective: 7/12/2023

Patient Responsibilities

Telehealth Responsibilities

- I will not record any Tele-Psychiatry sessions without written consent from my provider
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins
- I understand that I alone am responsible for the configuration of any electronic equipment used on my electronic device that is used for Tele-Psychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins
- I understand that I must be a resident of the State of Colorado to be eligible for Tele-Psychiatry services from my provider
- I understand that I must be physically in the State of Colorado at the time of any scheduled Tele-Psychiatry appointment
- I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-Psychiatry
- I have the right to withhold or withdraw my consent to use Tele-Psychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect my future care or treatment
- I understand that my provider has the right to withhold or withdraw consent for the use of Tele-Psychiatry during the course of my care at any time
- I understand that all rules and regulations that apply to the provision of healthcare services in the state of Colorado also apply to Tele-Psychiatry
- I understand that I can not attend an appointment while operating a motor vehicle, and I will not be driving at the time of appointment.

Attendance

- If you must cancel or reschedule an appointment, we require at least 24 hour notice (weekends not included)
- Cancellations that occur with less than 24 hour notice or if you fail to show up to an appointment, you will be charged up to a maximum of $125 for the session if seen for medication management services or up to a maximum of $100 for therapy services.
- Payment for the cancellation fee must be paid before rescheduling the next appointment.
- Continued cancellations and/or changing appointments by a client may result in the cancellation of continued services.
- Our providers reserve the right to cancel the relationship at any time if the client becomes non-compliant with care, is belligerent, disrespectful, a danger to the provider, malingers or otherwise is harmful to the practice in any way.
- If there is a negative balance that is owed, the balance must be paid prior to or at the time of the next visit.

Payments, Fees, Insurance, and Release of Billing Information

I. Payments

We want to ensure your focus remains on your well-being during your time with us. To facilitate a seamless experience, we kindly request that payments be settled at the time of your appointment, unless alternative arrangements have been made. If circumstances prevent you from making payment or if you prefer not to pay, we may need to reschedule your appointment for a later time.

For your convenience, we accept various payment methods, including personal checks, credit/debit cards, and money orders. Please make checks payable to Mile High Psychiatry, LLC.

II. Fees

Our goal is to provide personalized care tailored to your needs. For your initial medication management evaluation, lasting approximately 40 to 60 minutes, our standard fee is $285. This fee does not cover additional services like psychotherapy or care coordination. For initial therapy assessments our standard fee is $110. Understand these appointments are first billed to your insurance and if required a patient balance may affect you for any remaining portion left unsettled by your insurance.

Follow-up sessions usually last between 21 to 40 minutes and involve either psycho therapy alone or a combination of psycho therapy and medication management.The cost for these sessions is $175. Typically, there are no extra charges, but depending on your specific treatment plan, additional services may be necessary. These extra services can add up to an additional $100. Our standard fee for therapy follow ups is $100. Please keep in mind that fees may change, but we will let you know 30 days in advance if there are any adjustments. **Note:** A sliding fee scale is available for qualified applicants upon request.

If a balance is added to your account, you will be provided a billing statement with a thirty day grace period to make a payment. If the payment requested is not received within this thirty day time period, a late fee will be assessed and may be added to your account. Please be sure to contact our billing department as soon as you are able in order to set up a possible payment arrangement if you are experiencing any difficulties making payments. By signing this form you agree to the terms and conditions of our late fee policy. Late cancel/No Show appointment fees detailed in Patient Responsibilities.

III. Insurance

We currently accept various insurance policies. Clients are encouraged to contact their insurance company prior to their visit to confirm active coverage.

If we do not participate with your insurance plan, we will be considered "out of network." Clients seeking reimbursement for their sessions may need to consult their insurance company regarding mental health benefits for out-of-network providers. We will provide a paper "super bill" that can be submitted to the insurance company for possible reimbursement.

Certain insurance companies may have limitations on the number/frequency of visits and types of medications covered. Some forms of treatment or a large number of sessions may require prior authorization. In such cases, we may need to provide information about the diagnosis, history, and treatment plan to the insurance company.

All services and fees referenced above will first be billed to your insurance carrier. If the insurance company denies the fee for service or does not pay the full rate, the client will be responsible for the total unpaid balance.

IV. Release of Billing Information

I authorize Mile High Psychiatry, LLC to obtain and disclose any billing information necessary for the processing of payment and reimbursement for healthcare services rendered to me. This authorization includes the disclosure of relevant billing details to my insurance company and other entities involved in the payment process.

Prescription Policy

**** Please read carefully***

- MHP requires 3 business days minimum to process prescription(s) renewals/requests. Patients are responsible for knowing when medication(s) will need to be refilled. No early refills will be accepted.
- Prescriptions will *not* be refilled on Saturday, Sunday or major holidays. Prescriptions will not be filled on a "walk-in" basis.
- Random and/or regular lab testing via blood or urine is required from all MHP patients to ensure patient safety and proper patient care
- New symptoms and/or events require a clinical appointment. MHP providers are unable to diagnose or change medication regimens via phone request.
- No refills will be accepted if medications are overused, abused, misused, lost or stolen.
- Patients are expected to follow the dosage and instructions for medication precisely. Patients should take medications as prescribed and never skip doses unless directed by their healthcare provider.
- If it is found that medications are being provided through multiple providers for controlled substances or narcotics, Mile High Psychiatry reserves the right to dismiss the client. This is defined as drug diversion and/or misuse of medications.
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine.
- NO controlled substances or stimulants will be provided as "bridge" scripts. Patients are required to keep scheduled medication management appointments in order to receive refills for medications.

To request a refill of your medications:

- On a Mobile Device
- On a Desktop Device
- Phone-in during normal business hours only (8:30AM – 5:00PM)

DEA Requirement: New Patient as of November 1, 2023:

MHP conducts all patient appointments via virtual tele-psychiatry. A recent DEA ruling requires that any patient who did not establish care during the COVID19 Public Health Emergency be seen in person by a DEA registered provider if they are prescribed medication(s) that are considered a controlled substance (schedule II- V). Depending on the type of medication you are prescribed, you may be required to attend an in-person appointment at least once annually. If this applies to you, your provider will discuss options with you during your first visit. If you have any questions on this ruling, you can find more information on our website.

These protocols are per recommendations of the Colorado Board of Regulatory Agencies and DEA

Failure to comply with Mile High Psychiatry's prescription policy may be cause for immediate termination of prescriptive medications.

Treatment Plans Consent

Treatment plans are essential for guiding your care effectively, reducing costs, and expediting your treatment progress. We recommend creating a treatment plan within 14 days of your intake appointment, during significant changes in your care, or every six months.

For Health First Colorado patients, treatment plans are mandatory as per state and federal guidelines, and as with other Health First Colorado services no fees will be charged. Commercial insurance patients or self-pay individuals have the option to participate in this service, which is highly beneficial.

I understand that by signing this agreement, I assume all risks and responsibilities associated with my decision, and I agree not to hold Mile High Psychiatry liable for any outcomes resulting from my choice to opt out of the recommended treatment plan.

By signing below, you are indicating that you opt in to regular treatment planning. By choosing not to sign, you are indicating that you opt out of regular treatment planning.

Client Name (Printed):

_____

Client Signature: _____ Date:_____

Parent/Guardian Signature (If applicable): _____

Date:_____