BERNADINE MERKER, MS, LCSW-LLC
7000 E. Belleview Ave., Suite 350
Greenwood Village, CO 80111

303.770.0940 Phone
303.770.6501 Fax
720.884.7374 Emergencies

E-mail: bernmerker@merkercounseling.com
Website: www.merkercounseling.com

DIRECTIONS:

From I-25, exit at Belleview Ave. heading west (toward the mountains.) Go past Quebec St. and you will see building 7000 on the left side of Belleview. Make a left turn at the first place you can into the office building just west of ours (or make a u-turn on Belleview.) Work your way back to building 7000, and turn right into the parking lot. Take the walkway to the main doors, where you are on the 2nd floor, north side. The elevators are on the left and you will go to the 3rd floor. Exit elevators to the right to Suite 350. Exit elevators to the left to the restrooms.

Please let me know if this appointment will not work at least 24 hours in advance.

I look forward to meeting with you.

PRACTICE INSTRUCTION

Bernadine Merker, MS, LCSW-LLC
7000 E. Belleview Ave., Suite 350
Greenwood Village, CO 80111

Welcome to my counseling/consulting practice. I look forward to working with you. I believe that change is always possible. Motivation and willingness to try new behaviors, letting go of non-productive beliefs, and focusing on strengths rather than weakness can produce wonderful results in our lives.

I do not believe "in a one answer fits all people" approach. Everyone is unique, and that needs to be taken into account when exploring how to bring about understanding and change!

Support, humor, setting reasonable goals, developing a plan for how to reach your goals, building a sense of inner strength and flexibility, especially when times are difficult, and knowing how to care for yourself are important parts of the process.

Tools can include anything from reading material; visual imagery and music; recommending a movie, novel or poem that I think would be helpful; cognitive therapy; identifying your learning style and working with you using tools specific to your style, or family therapy. Setting and reviewing goals and work to do at home is always part of counseling! The past helps us to discover the road map which led to our present beliefs, feelings and relationships; creating a new map enables to arrive at a new destination. Being focused in the present is very important.

I have a Masters in Social Work and a Masters in Education. I am noted as an expert witness in Attention Deficit Disorder, counseling for Adolescents and Adults, and Needs Assessment for complex clinical cases. I have consulted in numerous court cases in Criminal, Family and Civil Court. I have extensive history working with adolescents, families, couples and individuals, and groups. I am experienced with anxiety and panic disorders, depression, mood disorders, ADD, learning disabilities, trauma and abuse, chronic illness, personal injury and disability.

I may refer you to another professional for an additional assessment or consultation. I believe that people who have alcohol and/or chemical dependency disorders that are not yet treated need to be in concurrent treatment for this, as counseling alone will not be effective.

Most clients come on a regular basis, such as weekly or every other week, and often work for 6 months to a year at a time. Sessions usually last 50 minutes, but may be extended to 75 minutes for couples, families or whenever indicated. I am strongly motivated to help you achieve your goals. Your motivation helps us to be successful.

Following is information about my policies and procedures.

Confidentiality

The information you discuss during a psychotherapy session is protected as confidential under law (CRS 12, 43,214 (l) (d)) with certain limitations.

- It is my policy to report suspected child abuse, without an investigation, to the proper authorities who may then investigate.
- I also may take some action, such as seek an order for your emergency or involuntary commitment, without your consent if I deem you to be a serious harm to yourself or another. Any action I take without your consent will be discussed with you.
- If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency.
- If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.
- If you chose to use your health benefit plan, you will have given your insurance or managed care company consent to obtain required confidential information for the purpose of determining eligibility for reimbursement.
- I may seek consultation from another mental health professional. However, your identity will not be revealed without your consent, and your privacy will be protected by that professional.
- Clerical persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative purposes.
- When I am away from my office for a few days, I may ask another licensed therapist to cover emergencies for me. Generally, I will tell this therapist only what he or she needs to know.

Health Care Benefits/Financial Policy

In the event that you choose to use your health care benefits and my services are reimbursable under your insurance plan, you will have to give me written authorization to release required information. Released confidential information may range from identifying information, diagnosis, dates and types of sessions and charges to a complete assessment with treatment goals and progress reports when your benefits fall under managed care. My policy is to provide only the least amount of information necessary for the purpose of authorizing benefits. I cannot be in control of the storage of confidential information nor access to your confidential information when it is given to a third party. The insurance company will determine benefit coverage and the kind of service for which they will reimburse. I will discuss with you my recommendations for treatment, and you will decide how you want to proceed.

Although I am on numerous insurance managed care networks, I may not be a member of your particular insurance. As a courtesy to patients, I will provide billing statements and/or completed claims forms based on information provided by you. However, it is your responsibility to verify coverage and to obtain all necessary preauthorization of services required by the insurance carrier. **You are responsible for seeing that my services are paid for, regardless of the decisions of your insurance company**.

PAYMENT IS DUE AT THE TIME OF SERVICE. **ALL clients, whether insured or uninsured, need to pay their co-pay at the time of service.** Acceptable forms of payment are cash, check, Visa or MasterCard. Responsibility for payment for services to a dependent child rests with the custodial parent who seeks treatment. We ask that you provide us with current Visa or MasterCard information so that we can utilize it for payment to keep your account current.

MISSED OR CANCELLED APPOINTMENTS - If you are unable to keep an appointment, please cancel as soon as possible. You will be charged for missed appointments and appointments not cancelled with 24 hour notice. Your insurance will not be billed for missed or cancelled appointments and they will be your sole financial responsibility.

Availability

You may leave a voice mail message 24 hours a day, and I or a designated backup therapist will attempt to return your call within 24 hours during the weekdays or on the first working day following a weekend or holiday.

In the event of an emergency, PLEASE SEEK CARE AT THE NEAREST HOSPITAL EMERGENCY ROOM OR DIAL 911.

During my vacations or absences from my practice, I attempt to designate a backup therapist to cover any emergencies.

Records

Records include identifying information, dates and types of sessions, an assessment and diagnosis, a treatment plan, progress notes, and any consultations or collateral contacts made. My private psychotherapy notes are kept separate, and are further protected from unauthorized access. Your records will be stored safely with attention to your privacy for at least 10 years as required by Colorado Statute. They will only be released with your written permission and direction, and if you were seen in couple or family sessions, all adults present would have to sign the release. It is my policy to not release an entire record, even with your consent. Instead, I may summarize the content related to the request. You will be granted reasonable access to your record, but not my psychotherapy notes. You may request, in writing, an amendment to your record. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you may have about the recordings.

Termination

Termination will usually be agreed upon mutually, but you are free to terminate at any time. However, in a few special instances I may decide to stop working with you even though you wish to continue. These include a failure to meet the terms of our fee agreement, a need for special services outside of the area of my competency, and prolonged failure to keep appointments and/or make progress in our work together. Should this occur, the reason for termination will be discussed with you, and you will be helped to make different plans for yourself or be provided with another referral source. It is good protocol to always schedule a final interview when termination by either party is decided upon.

I have read the preceding information and understand my rights and responsibilities as a client. I agree to the payment terms and understand that I need to provide 24 hours notice for a cancelled appointment, or I will be charged.

_____ _____

Signature **Date**

DISCLOSURE STATEMENT

Bernadine Merker, MS, LCSW-LLC
7000 E. Belleview Ave., Suite 350
Greenwood Village, CO 80111

DEGREES AND CREDENTIALS
Arizona State University, MSW 1977
Long Island University, MS 1977
University of Wisconsin, BA 1971
Colorado Licensed Clinical Social Worker #992525

The practice of both licensed and unlicensed psychotherapists is regulated by the Department of Regulatory Agencies under **CRS 12.43.214 (1)(c).** Questions or complaints may be addressed to:

Colorado State Grievance Board
1560 Broadway, Suite 1340
Denver, CO 80202
(303) 894-7760

Under this statute, **12.43.214 (1)(d) CRS,** you are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy is inappropriate and should be reported to the Grievance Board.

12.43.214 (1)(d) CRS states that information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section **12.43.218** and except for certain legal exceptions which will be identified by the licensee should any such situation arise during therapy.

I have been informed of my therapist's degrees, credentials, and licenses. I have also read the preceding information and understand my rights and responsibilities as a client.

_____ _____
Patient/Client's Signature (Guardian for Minor) **Date**

_____ _____
Therapist's Signature **Date**

CLIENT INFORMATION FORM

(Please print)

Patient Name _____ **Birth Date** ____/_____/_____ **Date of first appointment**____/____/___

Referred by: _____ ☐ **Family Doctor** ☐ **Psychiatrist** ☐ **Friend/co worker** ☐ **Westside**

REASON FOR SEEKING COUNSELING:_____

Home Address _____ **City/ST/ZIP** _____

Home Phone: (_____) _____-_____ OK to call? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Work Phone: (_____) _____-_____ OK to call? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Cell Phone: (_____) _____-_____ OK to call? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

Pager :(_____) _____-_____ E-mail_____ SSN_____

FAMILY INFORMATION:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Spouse (if applicable) and Children's Name	Date of Birth	Male/ Female	Relationship	Child from this union?	Child from other union (describe)?	Living with you?	Will this person be seen in counseling?	If seen, please provide SSN
		M / F		Yes / No / NA		Yes / No	Yes / No	
		M / F		Yes / No / NA		Yes / No	Yes / No	
		M / F		Yes / No / NA		Yes / No	Yes / No	
		M / F		Yes / No / NA		Yes / No	Yes / No	
		M / F		Yes / No / NA		Yes / No	Yes / No	

FAMILY OF ORIGIN INFORMATION:

Family Member -	Living or Deceased?	Date of Birth	Date of Death (if	Cause of death	Prior Medical, Psychiatric, Chemical
Mother-_____					
Father-_____					
Sibling-_____					
Sibling-_____					
Sibling-_____					
Sibling-_____					

EMERGENCY CONTACT:

Name _____ Relationship to Patient _____Home Ph _____ Work Ph _____

Address _____ City/ST/ZIP _____ Cell Phone _____

CLIENT INFORMATION FORM

(Please print)

Patient Name _____ **Birth Date** ____/_____/_____

OCCUPATIONAL INFORMATION:

If Employed:

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Student ☐ Retired- Date: _____

Employer: _____ Job title: _____ Years at job ____

Employer Address: _____ City/ST/ZIP _____

If Student: School_____ Year_____ If College or Technical list area of study: _____

Are you currently on disability? ☐ Yes ☐ No Date Disability Began ___/___/____ ☐ Short Term Disability ☐ Long Term Disability ☐ Social Security Disability

Disabling Condition(s): _____

HEALTH CARE PROVIDER AND TREATMENT INFORMATION:

Provider Name	Specialty	Last Seen	Condition(s) Treated by this Provider	Address	Phone	Fax
	Primary Care					
	Psychiatrist					

Please list all medical and psychiatric conditions below. Provide the treatments/medications including any previous counseling, In-patient/Out-patient treatment, Chemical Dependency treatment, etc.

Medical/Psychiatric Conditions	Date of Onset	Date Last Seen	Treatments (i.e. counseling)	Medication/Dosages	Facility and/or Treating Provider

CLIENT BILLING INFORMATION

(Please print)

Patient Name _____ **Birth Date** ____/_____/_____

TYPE OF BILLING: ☐ Insurance Billing ☐ Private Payment ☐ Third Party/Family Member Billing

GUARANTOR (Person responsible for the bill) INFORMATION:

Name _____ Date of Birth _____

Address _____ City/ST/ZIP _____
(If different from patient)

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell (_____) _____-_____

You may release information necessary for billing to this person. ☐ Yes ☐ No

CREDIT CARD AUTHORIZATION:

Credit Card: _____ Expiration: _____ Security Code: _____ ☐ VISA ☐ MC

I authorize Bernadine Merker, MS, LCSW-LLC to charge my card for the amount not covered by insurance (deductible, weekly co-pays or co-insurance).

_____ _____

Card Holder Signature Date

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured _____ Date of Birth ___/___/_____ SSN _____-____-_____

Employer: _____ Employer Address:_____

City_____ State_____ ZIP _____

Insurance Carrier _____ Member ID _____

Claims Address _____ Group # _____

City/ST/ZIP _____ Phone _____

Co Pay: $_____ Deductible:$ _____ Deductible Left: $_____ Yearly Max: _____

SECONDARY INSURANCE:

Is patient covered by any other health insurance plan or program through other family members? ☐ No ☐ Yes (If yes, complete below)

Name of Insured _____ Date of Birth ___/___/_____ SSN _____-____-_____

Employer: _____ Employer Address:_____

City_____ State_____ ZIP _____

Insurance Carrier _____ Member ID _____

Claims Address _____ Group # _____

City/ST/ZIP _____ Phone _____

Co Pay: $_____ Deductible:$ _____ Deductible Left: $_____ Yearly Max: _____

CLIENT BILLING INFORMATION

(Please print)

I understand and agree that payment is due at the time of service. Appointments cancelled less that 24 hours in advance will be charged to me, and not billed to my insurance. I agree that I will provide current credit card information and agree to have my credit card charged for any patient balance due. I further understand that insurance verification and billing is provided as a courtesy to patients, but I am responsible to verify coverage, obtain all necessary pre-authorization for services as required by my insurance carrier and accept that I am personally responsible for payment of services regardless of the decisions of my insurance company.

_____	_____	_____
Signature of Patient or Responsible Party	Date Signed	RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES

Bernadine Merker, MS, LCSW-LLC

Effective April 14, 2003

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.

My Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

"Protected Health Information, PHI", is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Not Requiring Your Written Authorization
Your mental health information may be used and disclosed in the following ways.

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.
- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** 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. 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.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.
- **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information
Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form for Protected Health Information.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, Bernadine Merker. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., and Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

Acknowledgement of Receipt of Notice of Privacy Rights

I, _____, acknowledge that I received or reviewed a copy of the Notice of Privacy Practices for

Bernadine Merker, MS, LCSW-LLC.

_____ _____

Patient Signature Date

CONSENT TO RELEASE CONFIDENTAL INFORMATION TO AN INSURER

Bernadine Merker, MS, LCSW-LLC
7000 E. Belleview Ave., Suite 350
Greenwood Village, CO 80111

Patient: _____
Date of Birth: _____
SSN: _____

Consent to Release Confidential Information to an Insurer enables me to release diagnosis, treatment dates, and treatment plan to your insurance company when submitting for payment.

NOTE: Without your signature on this form, your insurance cannot be submitted.

Dear Sir or Madam,

This form authorizes Bernadine Merker, MS, LCSW-LLC to release information from her/his record maintained while I was a client of Bernadine Merker, MS, LCSW-LLC from _____ to _____. The information to be disclosed is:

- ☐ That is needed to complete a required report
- ☐ A letter or statement containing dates of treatments(s) and a diagnosis
- ☐ A summary of treatment and progress
- ☐ Other: _____

This information is to be sent to my identified insurance carrier or its agents:

This information is needed for the following purpose(s):

- ☐ Health insurance benefits, reimbursements, payment for related services or other similar decisions
- ☐ Life or other insurance application, payments or other decisions
- ☐ Other:_____

The designated information about me ☐ may ☐ may not be transmitted by fax, electronic mail, or other electronic file transfer mechanisms. Bernadine Merker, MS, LCSW-LLC and the designated recipient ☐ may ☐ may not discuss by telephone the content of the information released.

I understand that, by law, I need not consent to the release of this information. This information is not required for my treatment. However, I willingly choose to release it for the purpose(s) specified above. I understand that I may revoke this release at any time except to the extent that action has been taken in reliance on my consent.

Also, please note the following points:

a. This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (42 C.F.R. section 2.31 (a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations.

b. This is strictly confidential material and is for the information of only persons who are professionally capable of understanding, appreciating and acting upon it using their specific and advanced professional training in the mental health field. No responsibility can be accepted by the practitioner if it is made available to any other person or persons who lack such training, or who would not treat it in a professionally responsible manner, or who otherwise should not have access to it, including the patient.

c. Re-disclosure or re-transfer of these records is expressly prohibited and such re-disclosure may subject you to civil liability.

d. Federal and State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Assignment of Health Insurance Benefits
My signature authorizes the payment, directly to Bernadine Merker, MS, LCSW-LLC, of benefits payable under my policy. I understand such payments will be credited to my account with Bernadine Merker, MS, LCSW-LLC. I further understand that I am financially responsible to Bernadine Merker, MS, LCSW-LLC for charges not covered or reimbursed by my policy up to the fee Bernadine Merker, MS, LCSW-LLC has agreed to accept.

Medicare Patients only
I request that payment of authorized benefits be made to Bernadine Merker, MS, LCSW-LLC on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

An individually signed photocopy of this release is to be considered as valid as the original.

_____ _____
Client or Personal Representative **Date**

☐ Copy accepted by releaser ☐ Copy refused and kept by practitioner

_____ _____
Signature of Client or Personal Representative Date

_____
If not the client, please print name and state legal authority to sign for client.

----------*For Practitioner Use Only*----------

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ Client was incapable of signing
- ☐ Other (Specify)_____

_____

_____ _____
Signature of Practitioner **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

Bernadine Merker, MS, LCSW-LLC
7000 E. Belleview Ave., Suite 350
Greenwood Village, CO 80111

Authorization to Release Information is to obtain information from past or other providers, or to provide information to other treatment providers, designated persons.

NOTE: This form is to allow me to speak with your family physician, psychiatrist, or any court or legal personnel you would like notified of your treatment.

I, _____, DOB _____ SSN_____ hereby authorize:
Client

Bernadine Merker, MS, LCSW-LLC at 7000 E. Belleview Ave., Suite 350, Greenwood Village, Colorado 80111, Phone: 303 770-0940 Fax 303 770-650, to release information to and receive information from the following designated professional:

_____ _____ _____ _____
Name title Street Address City State

_____ (____)_____ (____)_____
Zip Phone Fax

Please initial next to each type of information to be disclosed:

Evaluations _____
Diagnosis _____
Treatment Plan_____
Course of Treatment_____
Other _____
Medical/Hospital Records_____
Psychological/Medical Test Results_____
Mental Health Record Summary_____
Psychotherapy Notes _____

The purpose of such disclosure:

Ongoing Treatment_____ Medical Care_____ Consultation_____
Evaluation_____ Transfer_____ Legal issues_____
Coordination of Care_____ Health Benefit Utilization_____ Other _____

Exceptions: _____

The designated information about me __can __cannot be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Bernadine Merker, MS, LCSW-LLC and the above designated person __can__ cannot discuss by telephone the content of the information released.

This consent is in effect from_____until _____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

This authorization to disclose private health information is for the release of psychotherapy notes or purposes other than my treatment, payment or the related operations of the practice, and I understand that my authorization, or refusal, will not affect my ability to get treatment or payment. However, the Practitioner can condition those things (1) if my treatment is related to research, or (2) if my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party.

By my signature below, I acknowledge a receipt or review of this disclosure.

_____

Signature of Client or Personal Representative

_____

Date

Federal Regulations prohibit the receipt of this information from making any further disclosures of this information.