Dr. Elizabeth Asta, LLC

Pronouns: she, her, hers
Phone: 970-591-3256
Fax: 970-413-6962
Address: 80 Garden Center, Suite 106 Broomfield, CO 80020
737 29th St. Suite 102 Boulder, CO 80303
Email: drelizabethasta@gmail.com

INFORMED CONSENT FOR THERAPY

ABOUT ME

I am a psychologist licensed in the state of Colorado (License # 4767), granted by the Colorado State Board of Psychologist Examiners. I was trained in a Counseling Psychology Ph.D program, which was accredited by the American Psychological Association (Colorado State University, 2011). I am a generalist by training and utilize a variety of approaches. The most common techniques and methods that I use include interpersonal process therapy, dialectical behavior therapy, feminist therapy, and cognitive-behavioral therapy among others. If you have questions about my approach, want to learn more about these specific techniques, or what to expect from therapy, please ask me at any time.

The practice of both licensed and registered persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. Any concerns may be addressed to the appropriate licensing board or:

- Colorado State Grievance Board, 1560 Broadway Street, Suite 1350, Denver, CO 80202; 303-894-7800
- As to the regulatory requirements applicable to mental health professionals: A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

PSYCHOLOGICAL SERVICES

It is an important step you have taken to obtain support and seek therapy. The therapy experience truly varies depending on what the client is seeking. I believe that therapy works best when the therapist and the client collaborate with one another to make adjustments, redirect, or shift focus of the work as needed. There are many different methods I may use to work with the issues you hope to address. Therapy is most successful when you are committed to the therapeutic process, investing time and effort on the things we discuss, both during our sessions and at home. I welcome feedback on our work and appreciate your insights around what would help you get the most out of therapy. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

CLIENT RIGHTS

You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee. You may seek a second opinion from another therapist/psychologist or terminate therapy at any time. In a professional therapy relationship, sexual intimacy is never appropriate and

is illegal in Colorado. It should be reported to the appropriate Grievance Board. You have seven years post any incident with a therapeutic provider to report your grievance.

CONFIDENTIALITY

All information you share with me is strictly confidential (with exceptions noted below) in accordance with state and federal laws as well as professional ethics. Confidentiality means that the information you share will not be shared with anyone other than whom you designate by signing a written release of information form. There are times, however, when I may be legally or ethically required to disclose information with or without your permission.

Limits to confidentiality. Limitations of client held privilege of confidentiality exist and are summarized below. If a similar situation occurs, I will make every effort to fully discuss it with you before I take any action when at all possible. I cannot legally or ethically guarantee confidentiality:

1. When I believe you intend to kill yourself or harm another person;

2. When I believe a child, elder, or other vulnerable adult person has been or will be abused or neglected;

3. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, I cannot guarantee confidentiality when a judge may order my testimony if they determine the issue demands it, and when I must comply with that court order.

4. If you were to ever make a complaint to my licensing board, it is legal for me to provide the licensing board with requested information;

5. And if you have not paid your therapy bill, I may submit your balance to a collection agency after an allotted time has passed and after attempting to contact you first.

Professional Consultation. Consistent with standard professional practice, I may occasionally find it helpful to consult other professionals in their areas of expertise in order to provide the best treatment for you. During a consultation, I will not use your name and other identifying information. The consultant is also legally and ethically bound to keep the information confidential.

Email. I offer the option of using email as a means of communication about scheduling and routine questions. Please be aware that the privacy of email cannot be guaranteed. If you choose to use email to communicate with me about scheduling, do so carefully and with the knowledge that email can reside on terminals even after they have been deleted. Please use email only for scheduling purposes or routine issues.

Messages: I can be reached at 970-591-3256. If I am unable to answer the phone, please leave a message on my confidential voicemail. I typically check my messages at least one time per day and return calls as soon as possible. When leaving a message, please indicate if your call is urgent. Please inform me of good times to reach you if necessary.

Emergencies. This practice is not a 24 hour crisis intervention agency. If you are ever involved in a life-threatening emergency, call 911 or go to the nearest emergency room. Voicemail or email is not an appropriate method to communicate emergency information. I am usually able to return calls/emails within the same business day. However, in case of a life-threatening crisis; you should go to the nearest emergency room or call 911.

Insurance Reimbursement. If you choose to utilize your health insurance benefits to assist you with paying for treatment, you will likely be required to authorize me to release information to them about your treatment. Please see the section below on Insurance Reimbursement for more management of accounts and reimbursement. At times, I may use a billing specialist for the submission of insurance claims and management of accounts and reimbursement. This person is also required by law to abide by HIPPA regulations for maintaining client confidentiality and only has access to information necessary for management of accounts and insurance reimbursement. If you have any questions about this, please let me know.

Delinquent accounts. If your account has not been paid for 60 days, and payment arrangements have not been made, I may use legal means to secure payment. I will make every effort to work with you to avoid taking this step and see it is a last resort. In most collection situations, I am required to release the client's name, the nature of services, and the amount due.

The law offers more details about confidentiality and can be complex. I encourage you to review your rights and legal limits at the website listed below. If you ever have questions or concerns about confidentiality, please talk with me. (https://www.colorado.gov/pacific/dora/Psychologist_Laws).

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PRACTICE POLICIES

APPOINTMENTS & CANCELLATIONS

I normally conduct an initial evaluation that will last around 60 minutes. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we decide to begin therapy together, I usually schedule one session per week, lasting 55 minutes or whatever time we agree on. In certain crisis situations, sessions may be longer or more frequent if appropriate.

Once an appointment hour is scheduled, that time is reserved for you and you are responsible for attending that session. If you miss a session, you will be expected to pay the full fee unless you cancel at least 24 hours in advance of the scheduled appointment. Note that insurance companies will not reimburse for missed sessions, so you will be required to pay the full session fee rather than your full copay. If requested, I will try to find another time for you to reschedule your appointment. Please make every effort to provide as much notice as possible if you need to cancel as it increases the likelihood that I will be able to reschedule your appointment and so I may also be able to schedule another client during that hour.

RECURRING APPOINTMENTS

Generally, I prefer for new clients to have a recurring appointment time that is weekly, or bi-weekly in some instances. If you cancel or miss sessions frequently, I may not be able to reserve the appointment time for you. I will not give your appointment time to another client without first informing you of my concerns and attempting to find another appropriate solution. Please let me know if something is not working for you. I would like to be given the opportunity to help.

FEES

My fee for initial evaluation is $180. My fee for therapy is $165 for a 55 minute session and $140 for a 45 minute session. Sessions lasting less than 45 minutes or more than 60 minutes

are not typical, but we will discuss associated fees if we decide that a shorter or longer session becomes appropriate. While I reserve the right to raise my fees at any time, I agree to honor these agreed upon rates for one year from date of our first appointment. Payment is expected at the end of each session, in the form of cash or check, unless other arrangements have been made. If you are utilizing your insurance to pay for services, you are expected to pay your co-pay or any other charges for which you are responsible. It is important to me to make therapy accessible to my clients, and so I do offer sliding scale options for my clients. Please discuss this with me and we can negotiate a more reasonable rate, if you are unable to afford the full fee. Please discuss with me if you are having difficulty paying for services and we will come up with a solution together.

In addition to weekly appointments, I charge the amounts listed above for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. These services include report writing, phone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to bill for my professional time even if I am called to testify by another party. I charge $165 per hour for professional services I am asked or required to perform in relation to your legal matter. Payment schedules for other professional services can be discussed and agreed to when they are requested.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it may provide coverage for mental health treatment. I will provide you with assistance utilizing these benefits; however, you (not your insurance company) are responsible for full payment of fees. If it is necessary to clear confusion, I am willing to call the company on your behalf with your permission.

You should also be aware that some insurance companies require you to authorize me to provide a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in very rare cases). This information will become a part of the insurance company's files and will likely be stored electronically. Though all insurance companies claim to keep such information confidential, I have no ability to guarantee this. In some cases, they may share the information with a national medical information databank. This may become relevant to you in the future if you are ever asked if you received a mental health diagnosis.

RECORD REQUESTS

Due to the confidentiality established in our relationship, except in the conditions listed above, I will not release your records or communicate to others about your treatment unless you have signed a written release of information. As a client you are entitled to your own records,

but I will need you to sign a release of information as the privacy of that information can no longer be guaranteed when that information is given to you and leaves my office, and I want to make sure we have reviewed that together. Please let me know if you have any questions about this.

SOCIAL MEDIA AND COMMUNICATION

Due to the importance of confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on my personal social networking accounts (Facebook, Linked-in, etc.). If you have questions about this, please bring them up and we can talk about it.

TERMINATION

If I determine that therapy is not being effectively used or if your needs would be better met with another provider, I may end/terminate treatment after appropriate discussion with you and a termination process. I will not terminate the therapeutic relationship without first attempting to discuss and explore the reasons and purpose of terminating. Should you fail to respond to communication for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

If therapy is terminated for any reason, I can provide you with a list of resources or qualified therapists to treat you if you like. Regardless of the reason for termination of the therapeutic relationship, you are welcome to contact me to inquire about re-initiating services.

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CLIENT INFORMATION FORM

NAME: _____ DATE: _____

Preferred Name/Nickname: _____

Contact Info & Demographics:

Age: _____ DOB: _____ Ethnicity: _____

Gender: _____ Pronouns: _____ Sexual Orientation: _____

Romantic Relationship Status: _____

Address:_____
Street City/State Zip

Email Address: _____

Home Phone: ( )_____ Mobile (please circle): y / n

Work Phone: ( ) _____

Permission to contact work number (please circle): y / n

Employer: _____ Occupation: _____

Contact Person in Case of an Emergency

Name: _____ Phone #: ( )_____

Relationship to You: _____

Medical Information:

Physician's Name**: _____** Phone #:( )_____

Physician's Address: _____
Street City/State Zip Code

Significant Medical Conditions (recent or current):

_____

_____

Are you Currently Taking Medications (please circle): y / n

If yes, please list: _____

_____

Presenting Concerns:

Please indicate what brings you to therapy now: _____

_____

_____

Please indicate any cultural or spiritual identities which have played an important role/important roles in your life:

_____

_____

Please indicate any significant family concerns or conflicts:

_____

_____

Family Members

Family Member	Relationship to You	Age	Please list an history of mental health concerns

Please indicate if any family members have ever received inpatient treatment for a psychiatric disorder, emotional concerns, or substance abuse issue, and if so whom:

_____

_____

Symptoms Checklist:

I am experiencing (or have recently experienced) the following:

None = This symptom not present at this time
Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed feelings					Anxiety				
feeling hopeless					panicky feelings				
sleep problems					fears or phobias				
fatigue/low energy					obsessive thoughts				
poor concentration					compulsive behaviors				
Indecisive					health problems				
feeling worthless					appetite disturbance				
feeling overwhelmed					weight gain/loss				
irritability/anger					body image issues				
agitated/restless					restricted food intake				
impulsive behavior					binging/purging				
self-criticism					over-exercise use				
guilt/shame					alcohol use				
mood highs and lows					drug use				
feeling high without drugs					sexual assault/abuse				
overly energetic					verbal assault/abuse				
relationship problems					physical assault/abuse				
aggressive behavior					financial concerns				
violent thoughts					academic concerns				
thoughts about harming others					career concerns				
thoughts about ending my life					family problems				
suicidal behavior/attempt					lying/stealing				
self-mutilation					social isolation				
feelings of grief/loss					withdrawing from others				
death of someone close					sexual concern/question				
Other:_____					gambling issue				

ACKNOWLEDGEMENT

I have read and understand the information contained in the following documents:

Informed Consent
Practice Policies
HIPPA Notice of Privacy Practices
Client Information Form

_____ By providing my initials here, I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for Elizabeth Asta, PhD, as required by the Health Insurance Portability and Accountability Act (HIPAA).

_____ By providing my initials here, I acknowledge that I have read and understand the information contained in these documents regarding missed appointments and late cancellations, and I agree to be responsible for paying the full fee for my appointment if I do not cancel prior to 24 hours before the scheduled appointment.

_____ By providing my initials here, I acknowledge that I have read and understand the information contained in these documents regarding electronic communication and have indicated my preferences (below) for email communication.

_____Please initial here to indicate permission to use email communication to cancel or schedule appointments and/or to discuss billing concerns.

I have had the opportunity to discuss my questions and concerns regarding services with Dr. Asta during our initial interview, and my signing below indicates that I consent to the services and policies outline in the documents.

_____
Printed Name

_____ _____
Signature Date