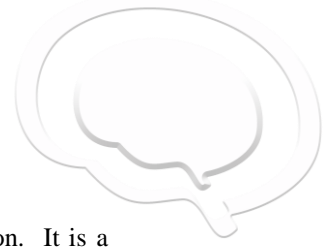


NEW CLIENT PACKET

Thank you for your interest in A WisserMind services.

This packet is made up of 5 pieces. Please make sure you have all 6 pages including this cover sheet.



1. **Your Privacy.** This document informs you of your right to protect your health information. It is a required federal document under the Healthcare Information Privacy and Accountability Act (HIPAA). **A signature on this document is required before the commencement of services.**
2. **Consent to Use and Release Information.** This form explains to you that we create and use medical records for you. These records are necessary for the delivery of our services. This form also allows us to contact the Primary Care Provider(s) (PCP) so that we can get a diagnosis from them. A diagnosis is necessary to be able to get reimbursement approval from insurance providers. Please make sure the name of the PCP is there as well as the office phone number. If you would rather, you may contact the PCP directly and get this information, but regardless we will need the providers contact information for our records. **A signature on this document is required before the commencement of services.**
3. **Insurance Information Form.** It is very important this form gets filled out correctly and completely. This will tell us whether or not there will be any benefit from Medicare, or another payer. It also documents the responsible party. **A signature is required on this form prior to the commencement of services.**
4. **Client Rights and Disclosure.** This page documents your rights as a client in the state of Colorado. **We are required to collect a signature on this form prior to commencement of services** to demonstrate that you have read and are aware of your rights.
5. **Simple Service Agreement.** In order to deliver services both parties have certain obligations and expectations. The service agreement defines those obligations and expectations. **You are agreeing to the terms set forth in the Service Agreement when you: 1) complete, sign and return the above forms, and 2) schedule your first appointment.** Continued participation in appointments also serves to demonstrate your ongoing acceptance of the terms in the Service Agreement.

Once you have these forms filled out, you may either fax or mail them to:

Fax: (303) 557-6240

Mail: A WisserMind

PO Box 17688

Golden, CO 80402

If you have any questions on these forms please call our Intake line at (303) 437-0989.

Thank you for your assistance! We look forward to working with you.

Denver/Boulder

303.437.0989

303.946.5003

Colorado Springs

719.641.0594

Scottsdale/Phoenix

480.269.1042

Fax

303.557.6240

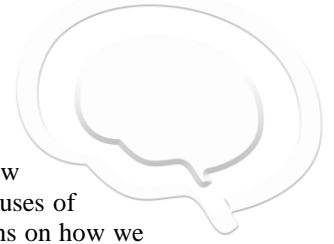
623.258.4187

eMail

info@aWisserMind.com

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Your Privacy



You have the right to protect your health information, and federal law requires that we let you know your rights and how we will use your information. This document explains those rights and our uses of your health information. A WisserMind will protect your privacy and will follow your instructions on how we can use your health information.

In order to be able to provide our services, we will need to be able to share information with your doctor, your insurance provider and with people and organizations that directly support A WisserMind in serving your needs. From time-to-time--for client's who live in multi-unit residence or assistance locations--we may be obligated to release name-only information to those locations which require such information to gain entrance to the location. In such instances when we provide your information to such people, they will only receive enough information to accomplish their duties. We will not share any more information than is necessary.

To protect your privacy, there is a federal law known as the Healthcare Information Privacy and Accountability Act (HIPAA). Under HIPAA, you can ask us to share some information and at the same time to request us to withhold specific details. Under certain circumstances we may not be able to honor your request to withhold information when we transfer your information to another individual. Specifically, court orders and medical emergencies may require us to release all of your information.

If you wish us to release information, or if you wish us to get your health information, you will need to give us written permission. Typically, we will keep your permission in effect for up to one year, but you can cancel it at any time by letting us know in writing.

If you have guardians or conservators (or those with your Power of Attorney) they are considered your legal representative and may receive your private health information, unless by law you are able to consent for your own healthcare treatment. If you are, then your private healthcare information will not be shared unless you sign an authorization form.

There are a few instances when your information might be released without your permission. Except as already stated, the release of your information will only be made without your authorization in the following circumstances: 1) requests by government organizations which oversee our practice; 2) in the event that we suspect abuse, neglect, or domestic violence has taken place; 3) as a "duty to warn" if you have threatened the life of another individual; 4) as required by court order; or 5) if you commit a crime.

You also have the right to confidential communications. You may ask us to communicate with you by alternate means or in a different location. You also have the right to request and receive a copy of your own healthcare information. There are a few circumstances when we may not be required to release your information to you. Examples of this might be psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other special circumstances. Finally, you have the right to know with whom we've shared your information for up to the last six years.

ACKNOWLEDGMENT: I hereby acknowledge that I received a copy of this notice.

Date	Print Name	Signature
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Please fax signed document to: (303) 557-6240.

Call (303) 437-0989 or email ClientServices@aWisserMind.com if you have any questions.



Consent to Use and Release Information

The following document (a HIPAA release) provides consent to the use and disclosure of health information for treatment, payment or healthcare operations.

I understand that as part of my (or my representative's) healthcare, A WiserMind originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care of treatment. I understand that this information serves as: 1) a basis for planning care and treatment; 2) a means of communication among health professionals; 3) a source of information for applying a diagnosis for billing purposes; 4) a means by which an insurance provider can verify billed services; 5) a tool for routine healthcare and quality operations.

I understand and have been provided with a **PRIVACY** document that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that A WiserMind reserves the right to change its notice and practices. I understand that I have the right to object to the use of my health information and understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the requested restrictions. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I also understand that A WiserMind requires health information and history in order to provide care and to correctly bill my insurance provider. As such, I hereby authorize _____ (my healthcare provider) who can be contacted at: _____ phone; _____ fax, to release to A WiserMind, my primary diagnosis, carried out to the 5th digit which supports the symptoms which I am experiencing.

PURPOSE OF THE RELEASE: For placing in the medical record and obtaining financial benefits from third-party payers (insurance providers).

I understand that my records are protected under federal regulations, including HIPAA and cannot be disclosed without my written consent. I understand I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. This consent automatically expires at the end of one year unless otherwise indicated.

I request the preceding uses or disclosures of my health information:

Signature of client

Authorized Representative Signature

_____ Accepted _____ Denied

Client Name (printed): _____ Date: _____

Please fax signed document to: (303) 557-6240. Call (303) 437-0989 or email ClientServices@aWiserMind.com if you have any questions.



Insurance and Billing Information Form

This information is necessary to be able to complete the Medicare or CMS 1500 standard insurance form for filing claims. Please complete and sign. Thank you.

Insurance Type: (check all that apply) (Inclusion of an insurance plan in this list does not represent benefit availability)

- Anthem Blue Cross/Blue Shield
 Humana
 Kaiser Medicare
 Medicare Part-B
 Other Blue Cross/Blue Shield
 Secure Horizons
 TRICARE
 United Behavioral Health
 Other Primary _____
 Other Supplemental _____

Client's Name: _____ Gender: Male Female

Street Address: _____ City: _____ State: ____ Zip: _____

Client's Telephone Number: (____) _____ Client's Date of Birth: ____/____/____

Insured's ID Number: _____ Medicare Part-B eligibility date: ____/____/____
(Client's Medicare number plus letter at end, eg 123-45-6789A)

Supplemental Insurance: _____

Subscriber Number: _____ Plan ID /Group Number: _____

Supplemental Insurance Phone number: (____) _____

Correspondence and Billing Address: _____

City: _____ State: ____ Zip: _____

Please list below **ALL providers** including their phone numbers that you are seeing, i.e. primary care provider, speech therapist, physical therapist, neuropsychologists, psychologist, psychiatrist.

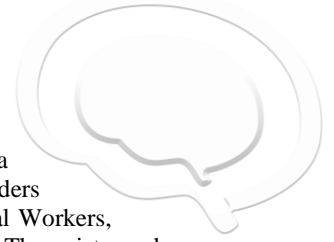
I authorize the release of any medical or other information necessary to process this claim. I authorize payment of benefits to A Wisermind, for services provided to me.

Signed: _____ Date: _____
Client's or Authorized Person's Signature

Print: _____
Name of Authorized Person if signing for client

Phone: _____
Phone number of Authorized Person

Client Rights and Disclosure



Thank you for choosing A WiserMind, we look forward to working with you. A WiserMind is a psychotherapy practice focused on the diagnosis, treatment, assessment and counseling of mental disorders and intellectual functioning. Our programs may use Licensed Psychologists, Licensed Clinical Social Workers, Licensed Mental Health Counselors, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Nurse Practitioners to deliver our services and assessments. The specific therapist assigned to deliver therapy for you or your family member will be appointed based on clinical needs, availability and other considerations.

A WiserMind provides two general types of therapy, Brain Activation Therapy™ and Psychotherapy. Brain Activation Therapy™ is focused on evaluating, treating and eliminating cognitive and emotional symptoms of various mental health conditions. Psychotherapy typically focuses on eliminating undesired emotions and enhancing quality of life, personal effectiveness and behavioral health. Either one or both of these therapies will be used in your treatment plan as defined by the assigned therapist and other consulted health professionals, as appropriate. In order for us to make provisions for diagnosis and treatment of any medical condition we shall collaborate with a physician. As a practice of non-physician-psychotherapists, A WiserMind does not diagnose, prescribe for, advise, or treat clients for medical problems.

Under Colorado Law (CRS 12-43-214) you have certain rights and limitations which you must be aware of:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of professionals in the field of psychotherapy. Questions or complaints may be addressed to: Colorado State Grievance Board; 1560 Broadway St., Suite 1350; Denver, CO 80202; phone 303.894.7800; fax 303.894.7764; web address: dora.state.co.us.

You are entitled to receive information about the methods of assessment and therapy, the techniques used, the duration of therapy (if known), and our fee structure. Furthermore you are also entitled to receive information (upon request) about any therapist in the employ of A WiserMind that is providing, or has provided, psychotherapy services to you. Such information includes the therapist's name, educational degrees, licenses, and credentials. Please ask your therapist, or your therapist's supervisor, should you wish any of the above information.

You have the right to seek a second opinion from another therapist or terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate. If sexual intimacy occurs, it should be reported to the Grievance Board of the Department of Regulatory Agencies, Mental Health Section.

Any information shared with your therapist during a therapy session is legally confidential, except as provided in section 12-43-218 of the Colorado statute and except for certain legal exceptions which will be identified by the therapist should any such situation arise during therapy. If the information is legally confidential, the therapist cannot be forced to disclose the information without your consent. This document does not limit your ability to file an official complaint or a file suit against A WiserMind, however, you are advised that per Colorado law (CRS 12-43-218 (2)), your right to confidentiality will be waived should you or your representative take such action. 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. Your therapist 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 personnel hired by A WiserMind may have access to limited confidential information. This information is protected from further disclosure.

Your signature, or the signature of your authorized representative, indicates that you have read the preceding information and understand your rights as a client.

Client

Date

Guardian or POA (if applicable)

Date

Simple Service Agreement

The purpose of this service agreement is to define a fair and simple set of expectations and responsibilities between the two parties.



Our agreement to you:

We promise that we will not begin delivering services before you ask us to start. Filling out these forms does not obligate you to start service, and we will not bill you for working with your insurance company or your doctor to verify benefits or obtaining the necessary diagnosis.

We promise that before we begin service, you will be informed of the insurance benefits as we understand them from consultation with your insurance plan. This will include what we understand will be your benefit limitations, and out-of-pocket expenses—if any—after insurance reimbursement.

We promise to use what we believe are professionally and clinically reasonable methods and services to improve your quality of life. While these services and methods have proven through research or experience to benefit those seeking help, we cannot warrant nor guarantee outcomes. Each person is different and responds differently.

Your agreement to us:

I authorize treatment of the person (client) named previously and agree to pay all fees and charges for such treatment. I understand that all charges are due and payable at the time of invoice. I am aware that billing of my insurance is a convenience service provided to me by A WiserMind. Insurance benefits do not release me of my financial responsibilities for my care. Therefore, I agree that if Medicare or other insurance does not cover services, or if A WiserMind does not accept assignment from my insurance, I am responsible for all charges.

I authorize payment of insurance benefits directly to A WiserMind. I authorize release of medical information needed to complete insurance company claim inquiries, quality assurance, and utilization management activities.

I agree that it is my responsibility to keep my appointments with A WiserMind. If I need to cancel my appointment with A WiserMind, I will provide at least 24 hours notice before the scheduled appointment. I understand that this notification period does not apply for verifiable medical emergencies. I agree that if I repeatedly miss my appointments or cancel without proper notification, that A WiserMind will invoice me \$75 for time and expenses related to each missed or cancelled session. I understand that these cancelled session charges will not be reimbursed by my insurance and are my responsibility to pay.

By scheduling my first appointment and by continuing to schedule new appointments, I am agreeing to the terms of service that are in effect at such time.