LESLEE BEDNARK, M.A. L.P.C.
P.O. BOX 202182
Denver, CO 80220
720-982-6624

NOTICE OF PRIVACY RIGHTS

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

1. During the process of providing services to you, I, as the provider, will obtain records and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below. As policy regarding the release of my underlying data, I will not release my files to third-parties without specific waivers and limitation of liability. Furthermore, the scope of my engagement is for engagement in treatment, not as an expert witness, as such services and scope of employment would require additional fees and associated costs. If there is uncertainty or disagreement regarding the scope of my professional obligations in regard to expectation of expert fees and testimony this document shall be conclusive. This Agreement does not automatically cover any expert reports, evaluation for court proceeding, and any such occurrence would result in an addendum to this original agreement. The provider will use and disclose protected health information in the following ways:

2. **Treatment.** Treatment refers to the provision, coordination or management of health care, including mental health care, and related service by one or more health care provider. For example, the provider will use your information to plan your course of treatment. The provider may consult with professional colleagues or ask professional colleagues to cover calls or the practice for the provider and will provide the necessary information to complete those tasks.

3. **Payment.** Payment refers to the activities undertaken by a health care provider, including a mental health provider, to obtain or provide reimbursement for the provision of health care. The provider will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company or other third-party payer for provided services. The information provided to insurers and other third-party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name and other information about your condition and treatment.

4. **Required by law.** The provider will disclose protected health information when required by law. This includes, but is not limited to

    1. reporting child abuse or neglect;
    2. reporting abuse of an at-risk adult;
    3. when court ordered to release information;
    4. when there is a legal duty to warn or take action based on imminent danger to others, danger to self, or gravely disabled;
    5. when a coroner is investigating the client's death; or

6. 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.
7. By written waiver of the client or a client's agent with verified power of attorney.

5. **Crimes on the premises or observed by the provider.** Crimes that are observed by the provider or the provider's staff, crimes that are directed toward the provider or staff, or crimes that occur on the premises will be reported to law enforcement.

6. **Business associates**. Some of the functions of the provider 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 needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information.

7. **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.

8. **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 that discussion. However, if the client objects, protected health information will not be disclosed.

9. **Emergencies.** In life threatening emergencies, the provider will disclose information necessary to prevent serious harm or death.

The provider may not disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization or a release of information, you may later revoke that authorization, but this must be done in writing.

YOUR RIGHTS AS A CLIENT

1. **Access to protected health information.** You have a right to inspect and obtain a copy of the protected health information the provider has regarding you. You do not have a right to inspect or obtain a copy of the psychotherapy notes of your provider. There are other limitations to this right, which will be provided to you at the time of your request, if any such limitations apply. To make a request to inspect or obtain a copy of health information pertaining to you, ask your provider.
2. **Accounting of disclosures.** You have a right to receive an accounting of disclosures the provider has made regarding your protected heath information.
3. **Alternative means of receiving confidential communications.** You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail bills or other materials to your home, you can request that this

information be sent to another address. Also, you can request confidential information be communicated to you through the use of email, fax, or voicemail messages.

4. **Complaints regarding privacy rights.** If you believe the provider has violated your privacy rights, you have the right to complain to the provider. If you file a complaint, according to Colorado Law your right to confidentiality shall be waived.

CONSENT TO TREATMENT OF MINOR CHILD

Name of Child: ___________________________________ DOB: ________________________

1. Consent to Evaluate/Treat: I voluntarily consent that my child will participate in a mental health evaluation and/or treatment with Leslee Bednark, M.A., LPC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning assessment results and treatment plan.
2. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered via psychotherapy, art and play therapy, and other modalities that best fit the needs of my child. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.
3. Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.
4. Confidentiality, Harm, and Inquiry: Information from my child's evaluation and/or treatment is contained in a confidential medical record, and I consent to disclosure for use by Leslee Bednark, M.A., LPC., for the purpose of continuity of my child's care. Per Colorado mental health law, information provided will be kept confidential with the following exceptions:
    1. if my child is deemed to present a danger to himself/herself or others;
    2. if concerns about possible abuse or neglect arise; or
    3. if a court order is issued to obtain records.
5. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/ or treatment of my child at any time by providing a written request to the treating clinician.
6. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.
7. Indemnification: By this agreement the Client shall indemnify treatment provider with respect to any reports, evaluation, professional opinion rendered by and through testimony or request for information via subpoena or court order. To include any legal action brought forth by third-parties or any person under the terms of this Agreement.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the

legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Date: Signature of legal guardian for minor under age 12

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: ______________________**Date of Birth**: _______________________________

Release To:________________________From:_______________________________________

I authorize the person/s, agencies or institutions entered below to share and receive any and all information and records concerning my medical or psychological treatment with Leslee Bednark, M.A., LPC and release the person agency or institution from any and all liability for providing such information.

LIMITS TO AUTHORIZATION

I wish to restrict my authorization entered above in the following specific ways:

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The above authorization shall continue in effect for a period of one year from the date entered below unless such authorization is rescinded in writing.

Signature of client or legal guardian: ___________________ **Date**: _____________________

Mandatory Disclosure Statement (required by C.R.S. 12-43-214)

Master of Arts in Community Counseling, University of Northern Colorado, Denver, Colorado, 2004, MCJ Criminal Justice, University of Colorado at Denver, 1994, B.A. Sociology with emphasis in Criminal Justice, University of Northern Colorado, Greeley, Colorado, 1991

LICENSES: Licensed #4763 Licensed Professional Counselor

The practice of licensed registered persons in the field of psychotherapy is regulated by the Colorado Department of Regulatory Agencies, Division of Professions and Occupations. As to the regulatory requirements applicable to mental health professionals: A Licensed Clinical Social Worker, a Licensed Marriage & Family Therapist, and a Licensed Professional Counselor must hold a Master's degree in the profession and have two years of post-masters supervision. A Licensed Social Worker must hold a Master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapy Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Registered Psychotherapist is registered with the State Board or Registered Psychotherapists, is NOT licensed or certified, and no degree, training or experience is required.

You are entitled to receive information from me about my methods of assessment and therapy, the techniques I use, my fee structure, and the duration of your therapy if I can determine it. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Generally speaking, the information provided by the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are provided in section C.R.S. 12-43-218 and the Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

I have read the preceding information and understand my rights as a client.

Client or legal guardian signature: ____________________Date: _________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

Name of Client: ____________________________

I hereby acknowledge that I have either (check one)

received a copy of the provider's Notice of Privacy Rights, or

requested not to take a copy because I have other copies from other providers and can and will request a copy at any point I want one.

Signature _____________________________ Date_______________________ If not the client, please print your name and indicate your relationship to the client

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ADDENDUM TO FEE AGREEMENT FOR SERVICES

FURTHERMORE, in consideration for the above-referenced services to be rendered by Leslee Bednark, M.A., LPC., the undersigned hereby makes this addendum to services of above-referenced agreement in the following manner:

This addendum to the agreement now shall incorporate rendering of expert opinion, testimony and/or report for purposes expanding the parameters of professional obligations and responsibilities. There is no guaranty of opinion or result.

As such, client(s) is required to advance a reasonable expert fee for testimony and report, inasmuch as such is a request outside ordinary and original agreement and fees shall require an additional $2,500.00 minimum payment. Such fees incorporate time necessary for preparing for hearing/trial and/or report. Fee shall include time expended in travel in furtherance of report and or testimony.

WHEREFORE, your signature below will acknowledge your approval of the foregoing and will indicate that you will remain personally liable for all of the charges. Please sign and I shall proceed forward accordingly. Your signature acknowledges receipt of the addendum to fee agreement for services and acknowledges your acceptance of the terms and conditions of this agreement.

WAIVER OF CONFLICT OF INTEREST

This addendum also provides an explanation of the conflict of interest involving multiple parties to the same transaction of events. This will confirm that you have been informed about the conflicts of interest inherent in any potential testimony or report. You should be aware, however, that such expert testimony may come to involve conflicts and separating interests based on objectives for each of you individually on certain issues. Therefore, it may, at some time in the future, become inconsistent with your interests and objectives to continue the counseling services, whereby both of you would be required to seek a new care provider. Moreover, such testimony and issuance of report may also result in the loss of the privilege for communications because anything disclosed by one client on a matter of common interest may be disclosed in testimony or report. The mere possibility of subsequent harm does not itself require disclosure and consent. The critical questions are the likelihood that a difference in interests will eventuate and, if it does, whether it will materially interfere with my independent professional judgment.

For these reasons, my normal practice in these circumstances, is to decline services to all parties. However, you have advised this office that neither of you wish to prohibit report and/or testimony at this time, and, instead, you desire that I present your multiple interests in connection with your court matter.

WAIVER OF CONFIDENTIALITY

I understand that by acting as an expert witness, I am waiving any rights to confidentiality and privileged information and will allow any and all information and records concerning my medical or psychological treatment with Leslee Bednark, M.A., LPC to be released for the specific purpose of completing an expert report and testimony.

Accordingly, we must request that each of you sign and return to us a copy of this letter, acknowledging that:

1. You have been advised potential conflicts associated with your respective interests; and

2. You nevertheless want me to proceed forward to include issuance of report or testify in connection with the matters discussed above.

3. You are waiving your right to confidentiality.

YOUR signature acknowledges receipt of this letter, and acknowledgment that you have been given an opportunity to discuss it with Leslee Bednark, M.A., LPC and also were provided with an opportunity to seek independent review regarding potential conflict, and acceptance of addendum to representation.

Date: ________________ **Signature: ______________________________**

Date: ________________ **Signature: ______________________________**