INITIAL CLIENT INFORMATION FORMS:

CLIENT CONTACT INFO:

Name:_____ DOB:_____ SSN:_____

Address:_____
STREET APT. #

_____
CITY STATE ZIP

Home #:_____ Work #:_____ Cell #:_____

EMERGENCY CONTACT:

Name:_____ Relationship to patient:_____

Address:_____
STREET APT. #

_____
CITY STATE ZIP

Home #:_____ Work #:_____ Cell #:_____

GUARDIAN (if patient under 18) AND/OR GUARANTOR (if other than patient):

Name:_____ Relationship to Patient:_____

Address:_____
STREET APT. #

_____
CITY STATE ZIP

Home #:_____ Work #:_____ Cell #:_____

Initial Assessment:

Employed: Yes No Length of Employment: _____
Occupation: _____
Religious affiliation: _____
Sex: _____ Sexual Orientation: _____Height: _____ Weight: _____

How did you hear about Lexie Garfield-Turner, Live BeYOUtifully, LLC (please circle)?

- Google Ad
- Facebook Ad
- I searched the web (ie: Google) and typed in _____ and Live BeYOUtifully, LLC. was a result.
- PsychologyToday.com
- Other website, if so please specify: _____
- A friend/family member/word of mouth
- I was referred by a doctor or other professional in the field, if so who? _____
- Other, if so please specify: _____

Why are you (or your child) seeking treatment at this time?

_____
_____
_____
_____
_____
_____
_____

Describe any current stressors in your (or your child's) life:

_____
_____
_____
_____
_____
_____

Have you had previous mental health treatment? Yes [] No[] If so, when, where, and for how long?

_____
_____
_____

What type of therapy did you have (*e.g. medication, counseling, dietary*)? _____
_____
_____

What has been helpful in previous outpatient treatment? _____
_____

Have you ever been hospitalized for any psychiatric treatment (*e.g. substance abuse, eating disorder, etc*)? If so when, where, and why?_____
_____
_____
_____

Any family history of psychiatric illness (*including depression, bipolar, schizophrenia, drug or alcohol abuse, panic attacks, anxiety, OCD, eating disorders, etc*). Please list the problem and which relative had struggled.
_____
_____
_____
_____
_____
_____
_____

Social History (If Applicable):

Marital status: Single [] Married [] Separated [] Divorced [] Widow [] Life Partner []
Spouse name: _____ Spouse age: _____
If married, how long? _____ Spouse's occupation: _____
If separated/divorced, date?_____ number of years married? _____
Children (name and ages) _____
Who is currently living in your household (age and relationship)?_____
_____

Family Members:

Mother:
Name: _____ age_____ occupation_____ if deceased, your age at the time of her death _____ , her age_____
cause of death: _____

Father:
Name: _____ age_____ occupation_____ if deceased, your age at the time of her death _____ , her age_____
cause of death: _____

Siblings:
Names: _____
Ages: _____

How did/do you get along with him/her?

_____
_____
_____
_____
_____

Personal/Developmental History

Highest level of education_____
Area of Study: _____

Any history of learning disorder Yes [] No[]
Any history of Gifted or accelerated learning Yes[] No[]

Have you ever served in the Military Yes[] No[]

Any history of trauma or abuse:

Sexual Yes[] No [] _____
_____
Physical Yes[] No[] _____
_____
Verbal/Emotional Yes[] No[] _____
_____

Substance Use/Abuse:

	Frequency	Amount	First use	Last use
Alcohol				
Marijuana				
Cocaine				
Amphetamines				
LSD				
Cigarettes				
Other				

Do you view your substance use as problematic? Yes No

Any history of legal problems (*e.g. divorce, bankruptcy, theft, etc*)? _____
_____
_____

Medical History:

Any current medical problems? _____
_____
_____

Describe any significant past illness? _____
_____
_____

Current medications and doses? _____

Mood Assessment:

Do you feel Depressed? Yes No
If so: What percentage of the day do you feel depressed? _____
What symptoms of depression do you feel you currently exhibit and how long have they been present?

Are simple tasks difficult for you to accomplish? YES NO
If so, are you able to complete them anyways?

Do you feel Anxious? Yes No
What percentage of the day do you feel anxious? _____

Have you ever experienced a panic attack? Yes No
When was your most recent panic attack? _____

Any OCD symptoms? Yes No If yes please explain _____
_____

Any PTSD symptoms? Yes No If yes please explain _____
_____
_____
_____

Body Acceptance & Eating Disorder Related Assessment:

Do you find yourself feeling shame about your body? Yes No
If yes, roughly what percentage of the day do you find yourself thinking about your body and wanting to change your body? _____

Do you actively or have you actively tried to change your body through extreme diet & exercise?
Yes No
If so, did you lose weight, change clothing sizes, etc.? If you lost weight how much did you lose?

_____

Do you find yourself thinking about your weight, shape, or size more than not? Yes No
If so, what do you find yourself most consumed with? _____

_____

Do you find yourself comparing yourself to those on social media, celebrities, friends, family members, etc? Yes No

Do you find yourself restricting your food intake for much of the day and binging for periods of time?
Yes No
If so, are these binges typically associated with sadness, anger, stress, anxiety, etc? Yes No

Do you find yourself obsessively counting calories, logging your food intake, or monitoring which/how many macros you consume daily? Yes No

Have you been in treatment for a diagnosed eating disorder in the past or currently? Yes No
If so, what was the diagnosis & where did you seek treatment?

_____

_____

Additional:

Has anything significant (any event, inicident, or action that YOU perceived to be significant, positively or negatively, even if others aware of the event, incident or action did not think it was significant) happened in your life in the past 2 years? If so, what and how has it effected you?

_____

_____

_____

_____

_____

Please add anything not covered in this questionnaire that you feel could help me understand your presenting struggle(s)?

_____

_____

_____

_____

_____

Recipient of Rights:

DISCLOSURE STATEMENT
DEGREES AND CREDENTIALS

Bachelor of Psychology, Michigan State University, December 2013
Master of Social Work, University of Michigan, April 2016

Licensed Social Worker: 0009921657

Regulatory requirements applicable to LSW and LCSW: A Licensed Clinical Social Worker (LCSW) must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Social Worker (LSW) must hold a masters degree in social work.

The practice of licensed social workers or licensed clinical social workers is regulated by the Mental Health Licensing Section of the Division of Registrations of the Colorado Department of Regulatory Agencies. The **Board of Social Work Examiners** can be reached at:**1560 Broadway, Suite 1340, Denver, CO 80202, (303) 894-7760**.

Under the Colorado Mental Health Practice Statute, 12.43.214 CRS, you are entitled to receive information about the methods of clinical work, the techniques used, the duration of clinical work (if known), and the fee structure. You may seek a second opinion from another licensed or registered mental health professional or you may terminate our work at any time. In a professional relationship sexual intimacy is inappropriate and should be reported to the Board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Generally, the information provided by and to a client during sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section CRS 12.43.218 and the HIPAA 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. Confidentiality is further discussed in my Practice Policies and Procedures.

I have read and discussed the preceding information, and I understand my rights and responsibilities as a client or the client's responsible party.

Printed Name of Client or Responsible Party (Guardian if child is under age 15):
_____

Signature Date: _____

Recipient of Rights continued:

If signed by Responsible Party, give relationship to client and authority to consent:

I, _____(client) give
_____ (responsible party),
_____ (relationship to client), the
authority to consent the above understanding of rights and responsibilities.

Hello! BeYOUtiful

Lexie Garfield Turner, LSW • Live BeYOUtifully LLC
2855 N. Speer Blvd, Suite C • Denver, CO 80211
Lexiedgt@gmail.com • 248.376.2726 • www.lexiegt.com

Notice of Privacy Practices:

NOTICE OF PRIVACY PRACTICES OF
Lexie Garfield-Turner, Live BeYOUtifully, LLC

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.

Effective April 14, 2003

If you have questions or requests about this Notice, please contact **Lexie Garfield-Turner, Live BeYOUtifully, LLC** member at 248-376-2726.

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 you, or the payment for your health care, and it 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:** If utilizing out of network insurance billing- 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 payers for services provided. The information provided to insurers and other third party payers may include 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 we are 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 a client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the 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 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; or (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 it is. Ask your clinician for the Request Form for 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 the 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, **Lexie Garfield-Turner, Live BeYOUtifully, LLC**. 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. Dept. of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Building, 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, _____ (client name), acknowledge that I received a copy of the **Notice of Privacy Rights** for Lexie Garfield-Turner, Live BeYOUtifully, LLC.

_____ _____
Signature of Client or Personal Representative* Date

*If Personal Representative, please print name and state legal authority to sign for the client:

_____ _____
Print Name Legal Authority

---------- *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

Hello! BeYOUtiful

Lexie Garfield Turner, LSW • Live BeYOUtifully LLC
2855 N. Speer Blvd, Suite C • Denver, CO 80211
Lexiedgt@gmail.com • 248.376.2726 • www.lexiegt.com

TREATMENT CONSENT
POLICIES AND PROCEDURES
CLIENT RIGHTS AND RESPONSIBILITIES

Welcome to my private practice. I look forward to working with you.

My focus is in helping you and/or your child to make change in the areas of need, and I am flexible in my approach in response to your direction. In my therapy, I work from a strengths-based perspective and believe that everyone has innate strengths and resilience. I believe that our vulnerabilities and setbacks are opportunities for learning, self-reflection, and growth. I approach treatment with an attitude of empathy, compassion, warmth, and a genuine concern for you/ your child's mental health and well-being. My greatest reward as a therapist is to see people walk through the valleys of disordered eating, self-hate, depression, trauma, anxiety and abuse and come out the other side with renewed hope and strength, living to their highest potential.

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 50-60 minutes.

Following is some information about my policies and procedures and your rights and responsibilities as a client of Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC.

Benefits and Emotional Risks

Psychotherapy is not easily described. It varies depending on the purposes and personalities of the client and therapist. Many different methods may be used to deal with the problems and these will be discussed in the treatment plan. Psychotherapy can have benefits and risks. Therapy often involves discussing difficult topics, and you or your child may temporarily experience more emotional pain. However, research shows that psychotherapy has many benefits, often leading to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Confidentiality

The information you discuss during a psychotherapy session is protected as confidential under law (CRS 12.43.214(I)(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.

- It is my duty, under Colorado statute to warn any individual in imminent danger of harm by you, as well as to report the danger to authorities.
- 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 I seek consultation from another mental health professional, your privacy will be protected by that professional. I will reveal only the necessary private information for the purpose of the consultation.
- If another mental health professional is involved in your mental health treatment and I determine that it is important for your treatment, I may collaborate in order to coordinate care. Your authorization may not be obtained, but you will be advised of this action.
- When I am away from my office for a few days, we will discuss how to handle any emergent need which may arise. If we decide to ask another licensed therapist to cover for me, I will then tell this therapist only what he or she needs to know to assist you.
- E-mail: All e-mail correspondence is not considered completely confidential or secure due to the ISP servers e-mails stop through coming to and from our inboxes. This allows law enforcement, ISP technicians, and hackers the ability to access such correspondence. You are also advised that any email sent to me via computer in a work-place environment is legally accessible by an employer. Please consider this before communicating with Lexie Garfield-Turner, MSW, LSW via e-mail. E-mail correspondence should be limited to the scheduling of appointments and other logistics.
- Texting: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.
    - I am ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply.
- Social Media: Friending- I do not accept friend or contact requests from current or former clients on any of my personal social networking sites (Facebook, Instagram, LinkedIn, etc). If you would like to 'like' or 'follow' Live BeYOUtifully, LLC's Facebook or Instagram page, I encourage you to do so. I

believe that adding clients as friends or contacts through my personal accounts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

- Internet Searches: While my present or potential clients might conduct online searches about my practice and/or me, I do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. If clients ask me to conduct such searches or review their websites or profiles and I deem that it might be helpful, I will consider it on a case by case basis and only after discussing possible impacts to our professional relationship and your privacy.

Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your struggles and typically whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-V; I have a copy in my office and will be glad to let you borrow it and learn more about what it says about your diagnosis.

Payment and Cancellation Procedure

Payment is due at the time of the session, or you can choose to pay for sessions in advance. Cash, check, or credit card is accepted. I do not accept barter for therapy nor will I run up an on-going bill, designed to be paid in full at a later date, for clients. If using a credit card: there is a $4.00 processing fee for sessions billed by Lexie Garfield-Turner, MSW, LSW using a card on file and a $3.00 processing fee for sessions paid for at the time of service via credit card reader. I offer a free phone consultation for you to learn more about my practice and to talk about the work we will do together. Sessions with Lexie Garfield-Turner, MSW, LSW, are $125/session. An initial in-person intake session lasts approximately 60-90 minutes and each session thereafter is about 50 minutes. Lexie Garfield-Turner, MSW, LSW has a limited number of low-fee/sliding scale client spots. If such spots are available, an appropriate fee can be arranged between both parties.

Phone Calls: Check-Ins with family members that are longer than 15 minutes will be charged accordingly. If the call was scheduled in place of a therapy session due to distance or travel on the client's behalf or Lexie Garfield-Turner, MSW, LSW's behalf (ie: she is out of town/unable to come into the office) the fee of the phone or video session will be the same as the fee agreed upon between Lexie Garfield-Turner, MSW, LSW and the client for in-person sessions (ie: typically $125 for 50 minute session). If the call is scheduled for the purpose of checking in as either the client or a family

member of the client, ie: progress, updates, crucial information, etc. and the call is longer than 15 minutes, the client will also be charged. The fee for such calls is $65 for a 30-45 minute phone call and $85 for a 45-60 minute phone call.

I ask that you please reschedule or cancel at least 48 hours prior to our session, if needed. If you cancel less than 48 hours in advance or if you do not show up for your scheduled appointment and have not given Lexie Garfield-Turner, MSW, LSW 48 hours notice in such an instance, the full cost of the session will be due.

Client credit card information will be kept on file in the event that the client cancels in less than 48 hours or does not show up to a scheduled appointment. This information will be kept in your secure and confidential file and will not be used unless the above scenario occurs.

Health Care Benefits

At this time I am not an in-network provider for any insurance companies. However, most insurance companies will reimburse partial amounts for my services as an out-of-network provider. This amount varies depending on your specific insurance policy as well as your specific deductible. I cannot guarantee any or all reimbursement but will provide a detailed invoice, also known as a Superbill, to clients seeking such reimbursement. Clients will be solely responsible for sending/submitting this Superbill to their specific insurance provider as well as taking any and all required action to receive the desired reimbursement. Please contact your insurance company to find out the specific information associated with your individual or family policy.

Families and Children

Whenever more than one related person is seen by me in individual, family or a combination of modalities, issues around confidentiality and conflicts of interest must be discussed. Related individuals must be fully informed about the planned work. In order to protect my role as therapist, each person must agree to respect the confidentiality of other family members. Any release of information about family work will require signed authorizations from all adults. In addition, each person must agree to not involve Ms. Garfield-Turner in litigation with the other.

Litigation

If you are involved in divorce or custody litigation, please understand that my role as a therapist is <u>not</u> to make recommendations for the court concerning parenting or custody issues, nor to testify in court concerning an opinion or issue involved in the litigation. By signing this disclosure statement you agree to not call me as a witness in any such litigation. Only court appointed evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. Information discussed in therapy is meant for your exclusive use in healing and growth. Evaluations

to be used for legal purposes should be obtained from a non-treating professional independent of the therapy.

Availability

I will return your calls or e-mails within 3 business days. However, you may leave a voicemail message 24 hours a day at 248-376-2726. As stated above, I will only communicate via text messaging for the purpose of scheduling and logistics of our sessions. I will return such text messages within 24 hours unless I am on vacation- see proceeding lines. It is my preference to discuss issues for therapy in scheduled sessions. We will have to discuss and individually plan for any anticipated needs for help with a crisis. During my vacations or absences from my practice, we will discuss your coverage needs and make appropriate arrangements.

Records

Records may include identifying information, dates and types of sessions, an assessment and diagnosis, a treatment plan, progress notes or treatment summaries, any reports or correspondence, consultations, or collateral contacts made and informed consent disclosures. My private psychotherapy notes are kept separate and are not a part of the record. These psychotherapy notes are further protected from subpoena and unauthorized access by HIPAA. Your records will be stored safely with attention to your privacy for at least 7 years as required by Colorado statute. In the event that I am no longer able to secure and monitor access to your record, another mental health professional will act as my professional representative. That professional representative will keep your records secure and accessible for the required 7 years. Your records are protected by Colorado statute, HIPAA regulations, and professional ethics. Records can only be released with your written permission and direction. It is my policy to not release an entire record, even with your authorization. Instead, I may summarize the content related to the request. Colorado Statute, CRS 25.1.803 limits release to a summary after termination. You will be granted reasonable access to your record, but no copy of the 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. You may request, in writing, an amendment or addition to your record. If you were seen in parent-child or family sessions, all adults present will have to sign for the release of any record or information gathered from our joint work.

Termination

Termination will usually be agreed upon mutually, but you are free to terminate at any time. You can do so by simply informing me. In a few special instances I may decide to stop working with you even though you wish to continue. The reason for this may include a failure to meet the terms of our fee agreement, or a need for special services outside of the area of my competency, or prolonged failure to 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, including referral to more appropriate resources.

Client Rights and Responsibilities

As a client of Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC., you have the following rights and responsibilities:

Rights

- You have the right to be treated with consideration, respect and dignity. To be protected from abuse or neglect.
- You have the right to fair treatment. This is regardless of race, religion, gender, ethnicity, age, disability, or source of payment. If this provider cannot treat you for any reason, you have the right to be referred to a provider who can and will treat you.
- You have the right to have information about you and the services received kept private unless the law says the information must be released to someone.
- You have the right to know how your problems will be treated and what you can expect during the term of treatment.
- You have the right to know about your treatment options and what may happen if you do not follow your plan of treatment.
- You have the right to be treated in the setting that is best for you and least confining.
- You have the right to refuse treatment as long as you do not put yourself or others in danger.
- You have the right to decide in advance what kind or treatment you would want in the future if you were to become unable to tell someone what you would want. Any advanced directives need to be shared with your treatment provider and will be included as a part of your treatment record.
- You have the right to see your records unless your provider thinks that would be harmful.
- You have a right to have your records treated confidentially, in accordance with the laws.
- You have the right to make a complaint concerning a violation of any rights listed here or concerning any other matter, and a right to be informed of the procedures and process for making such a complaint.

Responsibilities

- You have the responsibility to treat those giving you care with dignity and respect, as well as office materials with respect and care.
- You have the responsibility to give your provider the information needed to deliver the best possible care.
- You have the responsibility to ask questions about your care so you can understand your treatment and your role in that care.
- You have the responsibility to follow your treatment plan.
- You have the responsibility to keep all appointments and to be on time. Please refer to the "Payment and Cancellation Procedure" section above for more information.
- You have the responsibility to respect others' confidentiality. Please keep confidential any information (including identity) about others who might be seeking treatment at Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC.
- You have the responsibility to let me know if your name, address, phone number, financial status, or information changes.
- You have the responsibility to make payments for all services at the time of service, or to pay for your sessions in advance.
- You have the responsibility to let me know if you wish to terminate services.
- You have the responsibility to participate in your child's treatment (if applicable). You will be asked to give consent for treatment and to participate in the development and implementation of your child's treatment plan.
- You have the responsibility to assist me in coordinating your care with any outside provider. Your treatment provider can explain to you why this communication would be beneficial.
- You have the responsibility to notify your treatment provider if a crisis or emergency situation exists. A crisis or safety plan will be developed if applicable so you are aware of the steps to take and resources available in the event of a crisis or emergency.
- You have the responsibility to attend all sessions sober and not under the influence of any drugs or alcohol.
- You have the responsibility to discuss your opinions, concerns or complaints about your health care and these rights and responsibilities with your provider.

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. I authorize and consent to treatment with Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC. I have read this consent form and agree to all that it entails.

Print Client Name (Guardian if child is under age 15)	**Date**
Client Signature (Guardian if child is under age 15)	**Date**
Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC.	**Date**

Cancellation Policy:

If you, the client, have scheduled an appointment with Lexie Garfield-Turner, Live BeYOUtifully, LLC. it should be cancelled or changed ***no later than 48 hours before the time of the appointment***. If the appointment is ***cancelled in less than 48 hours OR*** if you, the client, do not show up to a scheduled appointment, and have not given Lexie Garfield-Turner, Live BeYOUtifully, LLC any prior notice, ***you will be charged the full fee for the session***. The card on file for you, the client, will be charged at the time of the late cancellation or within 15 minutes of the scheduled appointment time if you, the client, do not show up and have given no prior notice of this. See *Credit Card Authorization Form*.

I _____ (client name) understand and agree to Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC's cancellation policy and will adhere to the above policy beginning on _____ (today's date) until both parties are aware of the termination in services.

Lexie Garfield Turner, LSW • Live BeYOUtifully LLC
2855 N. Speer Blvd, Suite C • Denver, CO 80211
Lexiedgt@gmail.com • 248.376.2726 • www.lexiegt.com

Credit Card Authorization Form

Please note that this form will be securely stored in your clinical file and that you are willing to assume the risk for keeping this information on file.

I authorize Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC. to keep my signature and card information on file and to charge therapy session fees (individual, groups, workshops, couples, family or other) at the end of such sessions if I prefer not to personally pay with cash, check, or card at that time. My signature and card information will also be used for appointments scheduled with Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC. that are not cancelled within 48 hours of the scheduled appointment time OR if I do not show up and do not call to cancel within 48 hours prior. In the event that you do not cancel within 48 hours and/or do not show up to a scheduled appointment, the full fee of the session agreed upon by Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC and you as the client will be charged. In any of the above scenarios such charges will be made to my credit, charge, debit card, or flex spending account as filled out below for therapy services provided to:

_____

(Therapy client's name: Please Print)

I understand that this authorization is valid until cancelled in writing. I understand that this form along with all other personal client forms will be kept in an individual, secure file and will not be used for any reasons not listed in the preceding paragraph. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services will normally be posted to my credit/debit/flex card account within 72 hours of each session date and my session fee will be charged after the session is complete. Additionally, I agree that the card listed below may be charged by Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CDs DVDs, etc) that I have not returned within one week of termination. I understand that if a charge back fee is incurred, I am responsible for that fee. **Initial**: _____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC for any assistance and/or disclosure, I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC and those attempts have failed. **Initial**: _____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself that is not a minor that I am the parent or legal guardian of, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Lexie Garfield-Turner, MSW, LSW, Live BeYOUtifully, LLC. **Initial**: _____

……

I understand and agree to these terms and the conditions of this payment policy and agree to the conditions stated above:

Signature: _____

Cardholder Name (Print): _____

Relationship to client: _____

Card Type (circle one): Visa Mastercard Discover American Express HAS

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ **Security Code (3 digit): _____**

Credit Card Billing Address: _____

_____

Telephone Number: _____

I understand that therapy sessions cancelled in less than 48 hours or appointments that I do not show up to with any prior notice will be charged via this form and not by swiping my card.

Cardholder Signature: _____

Date: _____