LotusOM, LLC

CLIENT REGISTRATION

Name: _____ Date of Birth: _____
Gender Identity: : _____ Is the client under 12 years of age? Y ☐ N ☐
Sexual Identity: _____ Religion: _____
Do you feel safe in your home? Y ☐ N ☐
Ethnicity: _____ Primary Language: _____
Custodial Guardian/Parent's Name (if under 12): _____
Street Address: _____City/State/Zip: _____
Home/Cell Phone: _____ E-mail: _____
Client's Occupation: _____Employer: _____
Student/School: _____
Marital Status: _____ Children: _____ In Home: Y ☐ N ☐
Would you like to receive reminders about upcoming appointments? Y ☐ N ☐
Emergency Contact Information:
Name: _____ Relationship: _____
Home/Cell Phone: _____Other: _____
Are you or have you ever been a member of the military? Y ☐ N ☐
If yes, which Branch, Rank and Discharge Date. _____
Please list any know disability(s) that may affect your ability to receive counseling?

_____

What is the main reason you are currently seeking therapy, how long has this been affecting you, and how is this issue affecting your ability to function with occupational/social and daily living duties?

_____

_____

Primary Care Physician: _____ Ph #_____Last Exam_____
Current Medications (Name of Medication, Dose, Frequency):

_____

Date of last dental exam: _____
Do you have any known allergies? Y ☐ N ☐
If yes, please list:

_____

How did you find/hear about us? _____
Previous Mental Health/Therapy/Counseling (Provider, Dates of Service, Reason)?

_____

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Current/Past Diagnoses (i.e., Depression, Autism Spectrum, ADHD, Anxiety, Heart Conditions, Medical, Diabetes, etc.): _____

_____

Any Recent/Past Trauma and/or Loss:

_____

_____

Education and Occupation; Please provide details of educational/vocational accomplishments and current occupation.

_____

Please describe your current living situation.

_____

Are you able to meet in person or virtually for sessions? Y ☐ N ☐

Which do you prefer? In Person ☐ Virtual ☐ Do you have adequate transportation? Y ☐ N ☐

Are you lacking any basic needs (heat, shelter, food, clothing, etc.)? Y ☐ N ☐

Please describe your current social/emotional support (family, friends, groups, etc.)?

Please share a brief family history (mother, father, siblings, where you were born, upbringing).

Do you have any legal history?

_____

Is there any other relevant information that you believe will be helpful for the clinician to know about you that might impact or have barriers to your treatment.? Y N If yes, please explain:

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Please check any symptoms you've had in the last month (30 days):

- ☐ Difficulty falling asleep
- ☐ Difficulty getting out of bed
- ☐ Difficulty staying asleep
- ☐ Not feeling rested in the morning
- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed mood
- ☐ Feeling numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities, etc.
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects/situations (i.e., flying, heights, bugs)
- ☐ Repetitive behaviors (i.e., checking doors, counting, washing hands)
- ☐ Outbursts of anger
- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Feelings of guilt/shame
- ☐ Fear
- ☐ Changes in eating or appetite
- ☐ Voluntary vomiting
- ☐ Eating more
- ☐ Eating less
- ☐ Binge eating
- ☐ Use of laxatives
- ☐ Excessive exercise
- ☐ Weight gain/loss
- ☐ Difficulty catching your breath
- ☐ Increased muscle tension
- ☐ Unusual sweating
- ☐ Easily startled/feel jumpy
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations
- ☐ Racing thoughts
- ☐ Intrusive memories
- ☐ Thoughts about harming/killing yourself
- ☐ Thoughts about harming/killing someone else
- ☐ Self-harm/cutting
- ☐ Decreased ability to handle stressors

Have you ever attempted suicide? Yes☐No☐ When? _____

What means did you try? _____

Substance Use:

Alcohol _____ Frequency: _____ Age began: _____ Last use: _____ Current: _____

Cigarettes/ vape pens? _____ Frequency: _____ Age began: _____ Last use: _____ Current: _____

Other substances? _____ Frequency: _____ Age began: _____Last use: _____ Current: _____

LotusOM, LLC

Insurance Information:

PRIMARY Insurance Name: _____

Phone Number: _____ Name of Insured: _____

Member ID: _____ DOB: _ _ _ _ _ _ _ _ Group#: _____

SS #: _____ Address: _____

Employer: _____Work Phone: _____ Relationship to client: _____

SECONDARY Insurance Name: _____

Phone Number: _____ Name of Insured: _____

Member ID: _____ DOB: _____ Group#: _____

SS #:_____ Address: _____

Employer: _____Work Phone: _____ Relationship to client: _____

Please read carefully and sign at the bottom to attest to your agreement.

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to LotusOm, LLC in the amount due for services rendered to my dependent and/or me.

RELEASE OF INFORMATION: I authorize the release of any medical, behavioral health and/or substance abuse information necessary to process insurance claims for services rendered to my dependent and/or me. This consent may be revoked at any time in writing, except where action has already been taken based on this release. This release will automatically expire six months after the final payment has been received in the LotusOm, LLC account. This release is subject to State and Federal confidentiality requirements.

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for all services rendered by provider LotusOm, LLC. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, deductible and any non-covered services as identified in the disclosure statement.

CLIENT RELEASE OF INFORMATION TO GUARANTOR/THIRD PARTY AGENCY: I authorize LotusOm, LLC to release information to my guarantor or a third-party collection agency (for outstanding balances after 60 days, with collection charges added.)

By signing below, I consent to outpatient mental health evaluation and treatment recommended by the counselor(s) of LotusOm, LLC. I am aware that psychotherapy is not an exact science, and that no guarantees have been made regarding the results of treatment.

_____ _____

Client/Parent/Legal Guardian/Guarantor Signature Date

_____ _____

Provider Signature Date

LotusOM, LLC

Rights and Responsibilities as a Client:

- Be treated with respect, dignity, and regard for your privacy.
- Be free from discrimination based on race, religion, gender, age, disability, health status, or sexual orientation.
- The right to be free of mental, verbal, sexual and or physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living.
- Be informed of and fully participate in preparing the care plan and any changes in the plan.
- Get information on treatment options in a way that is easy to understand.
- Take part in decisions made about your health care. This includes the right to refuse treatment, except as required by law.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Ask for and get a copy of your medical record. You may ask for it to be changed or corrected.
- Have an independent advocate.
- Ask that we include a specific provider in our network.
- Get a second opinion.
- The right to know the charges of services.
- The right to receive a copy of the most recent license inspection report.
- Receive culturally competent services.
- Get interpreter services if you have disabilities or if you do not speak English.
- Be told if your provider stops seeing members or has changes in services.
- Tell others your opinion about our services. You can tell regulatory agencies, the government, or the media without it affecting how we provide covered services.
- Get medically necessary mental health care services according to federal law.
- Be free to use all your rights without it affecting how you are treated
- File a complaint if you believe your privacy rights have been violated.

You can file a complaint with the **U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. We will not retaliate against you for filing a complaint.

You have the Responsibility to:

- Learn about your mental health benefits and how to use them
- Be a partner in your care. This means:

  - Following the service plan, you and your therapist have agreed on
  - Participating in treatment and working toward the goals of your service plan
- Tell your therapist if you do not understand the service plan, if you do not agree with the plan, or if you want to change it.
- Give your therapist or doctor the information she/he needs to provide good care. This includes signing releases of information so that your providers can coordinate your care.
- Come to your appointments on time. Call the office if you will be late or if you can't keep the appointment.
- Cooperate with your insurance provider.
- To investigate the details of your insurance coverage and obtain prior authorization, clarify copayment and/or deductible amount and benefits. You are responsible for copayment/deductible amounts at the time of the visit unless other arrangements are made. You are responsible for full payment should payment be denied for any reason or should you wish to continue after authorized sessions are completed.
- Let us know when you change your address or phone number, and when you have lost or renewed your eligibility for health insurance.

Advance Directives:

Even though your therapist provides mental health services, federal law requires that we tell adult patients about Colorado laws relating to your right to make healthcare decisions and Advance Directives. You can receive mental health care whether you have an advance directive.

What is a Medical Advance Directive? Advance Directives are written instructions that express your wishes about the kinds of medical care you want to receive in an emergency. In Colorado, Medical Advance Directives include:

- **Medical Durable Power of Attorney:** This names a person you trust to make medical decisions for you if you cannot speak for yourself.
- **Living Will:** This tells your doctor what type of life supporting procedures you want and do not want.
- **Cardiopulmonary Resuscitation (CPR) Directive of "Do Not Resuscitate Order":** This tells medical personnel not to revive you if your heart or lungs stop working.

Your provider will ask you if you have an Advance Directive. If you wish, your provider will put a copy of your Advance Directive in your medical file. If a medical provider does not follow your Advance

Directive, you may call the Colorado Department of Public Health and Environment at 303-692-2980. For more information about Advance Directives, talk with your **P**rimary **C**are **P**hysician (PCP).

Well-Child Exams (EPSDT)

For clients under the age of 21, we are required to ask if any mental health issues were found in your child's last medical visit or well-child exam. We want to address the issues that were found and coordinate care with your primary care physician (PCP). Your provider will ask you to sign a release of information. If your child has not had a well-child exam within the last year, your therapist will suggest that you schedule an appointment. If you do not have a PCP or want a new PCP, you may call Health Colorado. For help in Denver, call 303-839-2120; outside of Denver, call 1-888-367-6557 (The call is free.); TTY**:** 1-888-876-8864.

Fees Structure and Session Length:

- Initial assessment--$175
- Individual sessions--$150 (Session length is 45-50 minute for individual and family sessions)
- Case Management Fee--$50—This includes phone calls, emails or letters, reports, letters written. To be billed directly to you, not your insurance company.
- Court Fees--$150 per hour
- Sliding fee or payment plan are available and should be discussed with your therapist.

Cancellation Policy:

- Cancellations must be made at least **24 hours in advance**.
- With less than 24 hours' notice you will be charged the full fee of $75, except in documented emergency situations. LotusOm, LLC requires credit card information for cancellation fee guarantee.
  Card number: _____Month/Year_____CVC_____
- The no show fee does NOT apply to Colorado Medicare/Medicaid clients.
- Due to high caseloads and waiting lists, **clients may be discharged after 2 no shows and/or inadequate 24-hour cancellation notification.**
- You will be responsible for payment for sessions when Medicaid is not in effect.

Emergency Access:

- **This is an outpatient setting; therefore, crisis calls should be taken by the following routes: you can call 1-844-493-8255 and speak to a crisis clinician at the Colorado Crisis Line 24/7. For life threatening emergencies please dial 911 or go to the nearest emergency room.**

- This provider participates in professional clinical consultation meetings with other mental health/SUD professionals. At times, care consultation occurs with discussion of the clinician's current caseload and your case may be discussed, if clinical consultation is needed.

I have read the preceding information; it has also been provided to me verbally _____
I have declined this information to be read to me ____
I understand my rights and responsibilities as a client or as the client's responsible party. I agree to abide by the procedures outlined above and I have been given a copy of this information.

_____ _____
Client/legal guardian/parent/signature signature Date

_____ _____
Provider signature Date

LotusOM, LLC

Disclosure Statement
The Counselors providing services at within this agency are:

- **Cris Menz, LCSW, ADS** received her Master of Social Work from University of Denver in 2020.
- **Kim Kanna, LCSW, ADS** received her Master of Social Work from Walden University in 2019.
- **Patrick Griego, LCSW** received his Master of Social Work from Colorado State University – Pueblo in 2021.
- **Iesha Salas, MSW** received her Master of Social Work from Newman University in 2022, and is currently clinically supervised under Cris Menz, LCSW.
- **Hallie Romero, MSW** received her Master in Social Work from Colorado State University-Pueblo in 2023, and is currently clinically supervised under Cris Menz, LCSW.

Here are some things that the State of Colorado and the Federal Government require psychotherapists to share with their clients: The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. **The Board of Registered Psychotherapists can be reached at 1560 Broadway Suite 1350 Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals**.

- Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state
- Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
- Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.

- Licensed Clinical Social Worker must hold a master's degree in social work.
- Psychologist Candidate, a Marriage and Family Therapist 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.
- Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision.
- A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.
- Information provided by and to 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 listed in section 12-43-220 of the Colorado Revised Statutes, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: www.dora.colorado.gov/professions/registeredpsychotherapists.
- 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. If sexual intimacy occurs, it should be reported to the staff Grievance Board, 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7766.
- You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____ _____

Print Client's name Date

_____ _____

Client/Legal Guardian/Parent Signature Date

_____ _____

Provider Signature Date

LotusOM, LLC

ACUDETOX

Treatment Description

_____Acudetox is a specialized form of acupuncture and is performed by placing five thin, sterile, single-use needles in your ears. The needles are generally left in place for 35-45 minutes. Treatment time may need to be altered for clinical or training purposes. State Licensed Acupuncturists, Licensed Auricular Detoxification Specialists (ADS) and/or other persons training to become Auricular Detoxification Specialists (ADS Trainees) administer the treatments.

Voluntary

_____I hereby voluntarily consent to be treated by acupuncture, and in particular the NADA acudetox protocol. I understand I may be treated with needles and/or small seeds taped to my ears. I have not been guaranteed any success concerning the uses and effects of acudetox. I understand I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reactions

_____I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy also may be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed physician.

Medical Referral

_____I understand if there is a worsening of my ailment or condition or if a new ailment or condition arises, that I should consult a licensed physician. I also understand that if I am currently under a physician's care I should continue if my physician and I deem it necessary and that my acudetox providers do not recommend altering medications or other therapies without first consulting my personal physician or provider.

Infectious Disease/Clean Needle Procedures

_____I understand that infectious diseases may be carried through the air, through physical contact, and through body fluids. I understand that acudetox practitioners/trainees follow the prescribed national standards of Universal Precautions to guard against the spread of infection using sterilized, prepackaged, disposable single-use needles.

_____I further understand that I am responsible for cleaning my ears prior to acudetox treatment.

_____ _____

Print Client's Name Client/Legal Guardian/Parent Signature

Date: _____

LotusOM, LLC

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES ☐ NO ☐
May we leave a message on your answering machine at home or on your cell phone? YES ☐ NO ☐
May we discuss your medical condition with any member of your family? YES ☐ NO ☐

If YES, please name the members allowed and what information may be shared:
_____

This consent was signed by: (check one) Client/Patient ☐ Legal Guardian/Parent ☐

Print Client's Name: _____

Signature of Client (or legal guardian if under 12) _____

Date: _____ Witness: _____

LotusOM, LLC

COUNSELING RECORDS RELEASE FORM

Patient Name: _____ DOB: _____

Person Requesting Records: _____

Relationship: _____ Daytime Phone: _____

Release my protected health information to the following person(s) entity for the following reasons:

_____

_____

Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I DO _____ I DO NOT_____ give permission for these records to be faxed to the above entity.

_____ _____

Client/Legal Guardian/Parent Signature Date

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person (s) or entity listed above. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged.

LotusOM, LLC

Coordination of Care

Client consents to release information to medical provider: **Yes** ☐ **No** ☐

Provider name: _____ Fax #: _____

Confidential Report to Provider Member information:

Patient name: _____. DOB: _____

The patient is being treated for the following problem(s):

_____

_____

_____

_____

_____

Information that may impact medical or behavioral health:

_____

_____

_____

_____

Date of first appointment: _____Date of last appointment: _____

_____ _____

Client/Legal Guardian/Parent Signature Date

_____ _____

Provider's Signature Date