Deborah S. Zwick, Ph.D.
Licensed Clinical Psychologist

Dear New Patient:

Attached please find new patient forms which include:

1. Patient Information (1 page)
2. Disclosure Statement (1 page)
3. Notice of Privacy Practices (4 pages)
4. Fee Agreement (1 page)

Please complete these forms at your earliest convenience and either fax to Dr. Zwick at (970) 926-0030, scan to drzwick55@gmail.com, mail via USPS to PO Box 2870 Edwards, CO. 81632 or bring to your first appointment. We will also need tele-medicine consent forms completed as part of the new patient package.

Our billing is set up for automatic credit card charges. You can provide that information directly to Dr. Zwick's confidential voicemail.

Please call Dr. Zwick if you have any questions.

Thank you,

Dr. Deborah Zwick

Email: dzwick1@live.com
Office Address: 30 Benchmark Road, Suite 204 Avon, CO 81620
Mailing Address: P.O. Box 2870 Edwards, CO 81632
(970) 376-1240 Phone (970) 926-0030 Fax

Deborah S. Zwick, Ph.D.
P.O. Box 2870 Edwards, CO 81632
(970) 376-1240

Patient Information

Date: _____ **Person completing form:** _____
(relationship)

Name of Patient: _____ **Birth Date:** _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____ **Fax:** _____

E-MAIL_____ **Cell Phone(s)**_____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____

Employer: _____

Address: _____

Parents (If Minor)

Father: _____ **Mother:** _____

Birth Date: _____ **Birth Date:** _____

Person to contact in case of an emergency: _____

Relation: _____ **Phone:** _____

FINANCIAL RESPONSIBILITY

Name of Guarantor: _____ **Relationship to Patient:** _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____

Birth Date: _____

Employer: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____

In Consideration for services, I hereby assume full responsibility for and agree to pay all the patient charges.

Guarantor: _____ **Date:** _____

Deborah S. Zwick, Ph.D.
P.O. Box 2870 Edwards, CO 81632
Colorado License # 2424

DISCLOSURE STATEMENT

The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. Any questions, concerns, or complaints regarding the practice of mental health may be directed to:

Colorado Board of Psychologist Examiners
1560 Broadway Suite 1350
Denver, CO 80202

Dr. Zwick is a Licensed Clinical Psychologist with over 30 years of experience, specializing in Clinical Psychology, psychotherapy and psychological assessment of children, adolescents, and adults. Her Curriculum vitae is available upon request.

You are entitled to receive information about methods of therapy and psychological testing, the techniques used, the duration of therapy- if known- and the fee structure.

You may seek a second opinion from another therapist or you may terminate therapy at any time.

You should know that in a professional relationship. sexual intimacy is never appropriate and should be reported to the Grievance Board.

You should understand that information provided by you during therapy is legally confidential in the case of psychologists. There are exceptions:

1) In cases of suspected child abuse and neglect;
2) When Dr. Zwick is required to report any threat of physical violence made by a client to both law enforcement and any potential victim;
3) When a client is in imminent danger to self or others and Dr. Zwick must initiate hospitalization;
4) If Dr. Zwick receives a court order to provide records regarding any threat to national security, she must comply.

ACKNOWLEDGEMENT:

I have been informed of my therapist's degrees, credentials, and licenses. I have also read the preceding information and understand my rights as a patient and I have received a copy of this disclosure statement.

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient Signature (Parent of Guardian if a minor) Date

_____ _____
Parent if minor Date

_____ _____
Therapist Signature Date

Deborah S. Zwick, Ph.D.
P.O. Box 2870 Edwards, CO 81632
(970) 376-1240

NOTICE OF PRIVACY PRACTICES
December 10, 2010

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.

DEBORAH S. ZWICK, PH.D. acts to maintain the privacy of protected health information and provide individuals with notice of the practice's legal duties and privacy practices regarding protected health information as described in this Notice. Our computers have passwords to protect our database, only the minimum necessary information is disclosed, and access of your medical information to our staff is limited to the essentials needed to perform their duties.

Provision of Notice: The practice will provide its Notice of Privacy Practices to every patient with whom it has a direct treatment relationship no later than the date of the first treatment to the patient after June 10, 2003 and post it in the waiting room. This Notice is available via mail to any member of the public to enable prospective patients to evaluate the practice's privacy practices when making his or her decision regarding seeking treatment from the practice.

Documentation of Provision of Notice: When a patient receives the Notice from the practice, the practice will request they sign their "Receipt of Notice of Privacy Practices" form. The form is filed with the patient's medical record. Should the patient refuse to sign the form, it will be noted in the record that the patient was given the Notice and refused to sign the form.

Effective Date and Changes to Notice: This Notice is effective June 10, 2003. The practice reserves the right to revise this notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or others privacy practices stated in the Notice. If the Notice is revised, it will be available upon request beginning on the revision's effective date. The revised Notice will be posted in the practice's reception area and made available to all patients, including those who had previously received their Notice. The patient will then be asked to acknowledge receipt of the updated Notice.

Complaints: If you believe your privacy rights are being violated, you may file a written complaint, describing the acts or omissions within 180 days of becoming aware of the violation. These letters should be addressed to Deborah S. Zwick, Ph.D., privacy officer, at P.O. Box 2870, Edwards, CO 81632. The practice will investigate each complaint. The patient also has the right to contact,

Secretary
U.S. Department of Health & Human Services,
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

The practice will not take any adverse action against any patient who files a complaint against the practice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

My office is permitted by federal law to make uses and disclosures of your health information for purposes of **treatment, payment,** and **health care operations.** Protected health information is the information we create and obtain in providing services to you. It may include documenting your symptoms, psychological examination, and test results, diagnoses, treatment and recommendations for future care or treatment. It also includes billing documents for those services.

An example of how we use your medical information for **treatment** is that as a courtesy, we telephone our patients to confirm their appointments. It is used for **payment**, when you may submit a bill to your insurance company, or provide information to your managed care plan reviewer.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of this office. The information in it belongs to you. You have the following rights:

- Request a restriction on certain disclosures of your health information (these requests may not always be granted, but will be carefully reviewed).
- Request a paper copy of the current Notice of Privacy Practices for Protected Health Information
- Request to inspect and copy your health record and billing record
- Appeal a denial of access to your protected health information, except in certain circumstances
- Request that your health care record be amended to correct incomplete or incorrect information. This request may be denied if the information was not created by us, was not part of the health information kept by the office, or is accurate and complete. However, if denied, you will be informed of the reason for the denial, and can submit a statement of disagreement to be kept with your record.
- Request that a communication of your health information be made by alternative means or at an alternative location
- Obtain an accounting of disclosures of health information (not including disclosures made at your request or authorization, or for treatment, payment, or operations)
- Revoke authorizations that you made previously to disclose information by writing my office, except to the extent that information or action had already been taken.

If you wish to exercise any of these rights, please contact Dr. Zwick.

Responsibilities of the Therapist

My office is required to maintain the privacy of your health information as required by law. This is why I am providing you with a Notice of duties and privacy practices regarding the information I collected and maintained about you. I will notify you if I cannot accommodate a requested restriction or request, and accommodate your reasonable requests regarding communicating health information.

Uses and Disclosures Not Requiring Authorization

As required by law, disclosure of abuse of a minor, disabled person, or of someone over age 60 is mandatory. Also, a patent's relative, emergency room personnel, law enforcement or paramedical personnel may have to be contacted and given information in the event of an emergency (i.e. a threat

to health or safety). I may disclose to the Food and Drug Administration (FDA) heath information related to adverse events related to medications, nutritional supplements, or other products.

Disclosure Requiring Authorization

In Colorado, specific written authorization is required to disclose or release information regarding mental health treatment (except in an emergency), alcoholism or drug abuse treatment, or AIDS (Acquired Immune Deficiency Syndrome). The federal HIPAA laws allow disclosure of necessary information required for purposes of treatment, payment, and health care operations.

_____

Acknowledgement of receipt
(Patient signature)

Deborah S. Zwick, Ph.D.
P.O. Box 2870 Edwards, CO 81632
(970) 376-1240

Receipt of Notice of Privacy Practices Form

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the psychologist has reserved a right to change his or her privacy practices that are described in the Notice. I understand that a copy of any Revised Notice will be provided to me or made available upon written request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the psychologist. I also understand that I will not be able to revoke this consent in cases where the psychologist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the psychologist's office.

:

_____ _____

Signature Date

If you are not the patient, please specify your relationship to patient (i.e. parent_____)

Patient's file

Deborah S. Zwick, Ph.D.
P.O. Box 2870 Edwards, CO 81632
(970) 376-1240

Fee Agreement and Office Policy

The information, guidelines, and policies set forth herein are offered so that the patient will have a full understanding of office procedures, billing policy and patient payment policy. This will also set forth the fee agreement. Current rates for professional services are as follows:

OUTPATIENT PSYCHOTHERAPY AND CONSULTATIONS	$230.00 per session (45 min.)
(Individual, couple or family)	$310.00 per session (1 hour)
PSYCHOLOGICAL TESTING	$250.00 per hour
FULL BATTERY, does not INCL. FEEDBACK SESSION	$3500.00 - $4300.00
COURT RELATED work, appearances, travel &	
Expert testimony	$425 per hour
Equine Therapy	$285 per session

Dr. Zwick's billing cycle is from the 1st through the end of each month. All patients will be sent an account statement itemizing those charges incurred during the billing cycle, plus any accumulated charges from previous month(s).

1. ***Patients are expected to pay for services at the time of the visit.*** It is considered the patient's responsibility to provide all necessary billing information. The patient acknowledges and agrees that it is his/her sole responsibility to pay for services rendered. **DR. ZWICK DOES NO INSURANCE BILLING, AND THEREFORE IT IS UP TO THE PATIENT TO SUBMIT THEIR OWN CLAIMS.** However, she will furnish necessary documents for patients to submit.

2. Patients will be charged at regular therapy rates for appointments not canceled, or canceled less than 24 hours before the scheduled appointment.

3. There will be no charge for telephone calls dealing with appointment scheduling. Telephone consultations of a psychotherapeutic nature will be billed at regular therapy rates. When treatment coordination, planning, or consultation is required for psychotherapy, Dr. Zwick's regular therapy rate will be charged for attendance at special meetings. When reports are requested from the provider, the provider's regular therapy fee, prorated, will be charged for the time necessary to write, dictate, and review the same. No reports will be sent out without prior written authorization and consent from the patient, or in the case of a minor, the parent thereof.

4. Monthly statements not paid in full when due will draw interest at the rate of eighteen percent (18%) **ANNUAL PERCENTAGE RATE** on the unpaid balance, which translates into a periodic **INTEREST** or **FINANCE** charge of one and one half percent (1.5%) per month. A ten dollar ($10.00) rebilling fee will be added, at the sole discretion of the provider, to each account showing accumulated charges from the previous month. In addition, if it is necessary to initiate legal proceedings, consultation or advice to secure payment of the patient's incurred charges, the patient agrees to pay the provider's reasonable collection / attorneys' fees and costs associated therein.

5. Patient acknowledges that psychotherapy is not an exact science. Patient acknowledges that no guarantees or assurances have been made to him/her, nor will any be made. Patient further acknowledges that his/her obligation to pay the provider's charges is not related to the success of the treatment accorded to the patient by the therapist.

6. Joint Custody: If **both parents** of a minor share fiscal responsibility, then **both parents** must sign the Agreement for Services form, and must provide their portion of the session fee at the time of service. In addition, **both parents** must give their written consent for the treatment/assessment of their child.

Until a signed copy of this form is placed on file, the patient is responsible for payment in full regardless of insurance coverage on the account. The patient's signature below evidences his (her) approval of all terms, conditions, and policies outlined above.

_____ _____

Date Patient (or Patient's parent or guardian in the case of a minor)