2024 Returning Patient Forms

Welcome! Weekly sessions will benefit you the most and help you reach your goals the quickest. I am available to discuss any of your assumptions, problems, or possible side effects in our work together.

Attached are the 2024 forms for continuing patients to complete. If your name or address changed this year, let us know. Otherwise, please take a few minutes to read over these forms and understand our office policies. Your signature is required on pages 2, 4, 5, & 6.

If you have adobe acrobat, you can use that to send me the forms. If you don't have Adobe, the best way to complete the forms is to print them, sign them, then scan them and email them back to me. You can also take a photo of each one and email them back to me. Be sure that your photos of the forms are clear and allow me to read all your responses. A typed name in a signature box counts as a signature. For security, I will request your credit card information at the start of our first session.

It is natural that therapy comes to an end at some point. Ending therapy can sometimes be difficult. I will discuss with you in advance if I think we need to end therapy. I ask that you discuss this with me as well. Saying goodbye is best done in a session so that we can review our work together and set aside additional time as needed.

Thank you. Chris Kalamon, LCSW

CREDIT CARD AUTHORIZATION

Everyone must have a credit card on file (VISA, MC) as a backup for late cancellations, no-show appointments, and late payments. This information is collected during your first visit, reviewed at the beginning of every year, and during the year as necessary. Health savings account cards may also be kept on file but must still have a back-up credit card in case HSA funds are depleted.

By signing below, I authorize Chris Kalamon, LCSW, to draft my credit card on file for therapy or related services including payments for Late Cancellations or No-Show fees as described in the Financial Agreement. There is a 3.55% admin fee applied to all credit card charges.

I also authorize the provider to send email or text receipts of payments made. I acknowledge that this credit card information will be kept on file via PCI-compliant encrypted code.

This authorization expires six months from the date of our final therapy session. By signing below, I confirm that I have read and understand the credit card policy.

Date_____**Name**_____

Signature (Electronically signed by patient)_____

Please have your credit card information ready to share with me at the start of your first 2024 session.

CHRIS KALAMON, LCSW

2024 FINANCIAL SERVICES AND FEES

This summary works in conjunction with our Informed Consent. Collaboration between therapist and patient will provide the greatest benefit based on your diagnosis(es) / presenting clinical concerns.

In the case of a mental health emergency, please contact 911 or the following numbers: **Colorado Crisis Services 844-493-8255; Suicide Crisis Line 800-SUICIDE.**

We raise our fees annually (usually at the beginning of the year) to allow for inflation and increased overhead costs (liability insurance, licensure requirements, mandatory trainings and CEUs).

PAYMENT by VENMO. **Please read – you may need to pay Venmo fees.** Payment is due before your session begins. You may pay by VENMO to Chris Kalamon @Chris-Kalamon. The account has my photo on it. Do not tag the payment as a purchase or a service, or our office will have to charge you the Venmo fee of $3.00 or more. This can also happen if you have a Venmo business account and pay from there. If you identify your payment as a personal payment, there are no additional fees.

CREDIT CARDS. The office will charge your credit card before your appointment if that is your preferred form of payment. All credit card charges are assessed a 3.55% admin fee. See separate credit card policy form for more information.

LATE CANCELLATION / No Show Fees. The full fee is charged if you miss an appointment or cancel with less than 24 hours' notice. This policy applies to everyone. To be fair, we must keep the fees at the same level for everyone; we can't make exceptions. For ethical and professional reasons, we do not offer discounts. You have access to the calendar 24/7 to change or cancel an appointment and avoid these fees. The calendar does not allow late cancellations; notify us by email, text or phone about these.

Standard Psychotherapy $160

Extended Therapy $210. Fees for this service are prorated every 15 minutes.

Individual Integrated Biopsychosocial Assessment First two visits, then as needed - $240 per session.

EMDR Heal from emotional distress due to disturbing life experiences. $210

Couple's Counseling. 1st session $275 / 75min. Ongoing sessions $225 / 60min.

Phone Calls, Telephone Management. phone calls to patients, doctors, other professionals, etc. Prorated every 15 minutes.

Emails & Texts. Emails and texts to patients, doctors, other professionals, etc. Prorated every 15 minutes.

Reports/Requests. Summary reports, attorney requests, disability paperwork, life insurance, FMLA, etc. Minimum charge of $210, then prorated every 15 minutes.

Insurance, Victim Compensation. We do not accept insurance nor have a relationship with any company. If we agree to work together, all communication with your insurance company will be between you and

them. If, for some reason, your insurance company demands communication with us, it is considered billable time payable by you. A $420 deposit (for two hours' time) is required before any communication occurs.

We also no longer accept payment from a victim compensation service for new patients. You will need to pay in full for your session then submit a claim to victim compensation for reimbursement to you.

COURT / Custody / Divorce. We will NOT testify in court concerning opinions on issues involved in any litigation, and we ask you to accept our policy. Do not use our services if you believe you will be involved in litigation. If you go to court, you will have to ask another professional to testify. If you become involved in legal proceedings that demand our participation, you will be expected to pay for all our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge $400 per hour for travel, preparation, attendance and other requirements, port-to-port. A $3200 deposit is required prior to any work.

For more information about your right to a GFE, visit www.cms.gov/nosurprises.

My signature confirms that I understand my rights, understand that I am responsible for communicating with my insurance company on all issues, and agree to my financial responsibilities,

Date_____**Name**_____

Signature (Electronically signed by patient)_____

Telehealth Appointment Consent Form

This consent is for all telehealth services provided to me by Chris Kalamon. Telehealth is the use of the Internet to provide remote health care for patients. Such care may come from doctors, nurses, mental health providers, and professional health educators.

Specifically, a health care professional will be communicating with me remotely via the Internet using doxy.me web-based audio-video software {referred to in this form as Telehealth Appointment). Doxy.me only hosts the software and does not provide medical advice or information. This Telehealth Appointment may be for diagnosis. continuity of care and treatment, testing, or medical consultation deemed necessary by my Healthcare Provider or me.

I understand that during a Telehealth Appointment:

- details of my medical history and personal health information may be discussed with me and/or other health professionals.
- audio, video, or photo recordings containing medical details may be transmitted via secure channels and those details may become part of my permanent medical record.
- all confidentiality protections granted to me by various state and federal laws also apply to my care during this appointment.
- industry-standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption.
- there may be security and privacy risks associated with Internet-based communications.
- there are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider.
- either my Healthcare Provider or I can discontinue the Telehealth Appointment if either of us feels that the information obtained through remote communications is not adequate *for* diagnostic decision-making or *for* providing the care I desire.
- in addition to my Healthcare Provider named above, I will be informed of any other person(s) who may be present during the appointment and have the right to have them leave the viewing and listening area.
- to maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the virtual appointment.
- due to the limitations of telehealth that are out of my control (such as an unreliable internet connection). I will call local authorities (9-1-1) to assist me with a medical emergency.
- I have the right to omit or withhold specific details of my medical history/physical examination that are personally sensitive.
- my Healthcare Provider may advise me to seek immediate treatment or determine that there is a medical emergency and, as such, local authorities may be given my personal details to assist me:
- the communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my Healthcare Provider.

Emergency Procedures specific to Telehealth Services:
I understand that if I am having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot resolve remotely, Chris Kalamon may determine that I need a higher level of care. I agree to provide an Emergency Contact Person (ECP) who she may contact on my behalf in a life-threatening emergency.

I agree to verify that my ECP is willing to come to my location in the event of an emergency. Additionally, if Chris Kalamon, my ECP or I determine that it is necessary, the ECP agrees to take me to the hospital or call the police to escort me to the hospital. My signature at the end of this form indicates that I understand all of this.

ECP's Name_____**Phone**_____

By Consenting to a Telehealth Appointment:

1. I agree to engage in remote audio-visual communication with my Healthcare Provider.
2. I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed.
3. I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be offered alternate services or options.
4. I understand that I may be responsible for co-payments, deductibles, or other charges from my Healthcare Provider, and additional charges may occur for services related to this appointment.
5. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Healthcare Provider.
6. I have the ability to ask direct questions to my Healthcare Provider about this appointment, including details about the Healthcare Provider's privacy policy.
7. If my questions are not answered to my satisfaction, I have the right to terminate the appointment.
8. I am at least 18 years of age.
9. I agree that my Healthcare Provider can contact my Emergency Contact Person (ECP) or the police on my behalf in a life-threatening emergency.
10. If the telehealth session cuts out due to any technological issues, I understand that my Healthcare Provider will call me on the phone to complete our session.

Date_____ **Name**_____

Signature (electronically signed by patient)_____

WRITE DOWN ANY ADDRESSES WHERE TELEHEALTH SESSIONS MAY TAKE PLACE:

Primary Home:_____

Secondary Home:_____

Primary Office:_____

Secondary Office:_____

Additional Addresses:_____