A New Outlook Recovery Services
Colorado TMS Services
1510 W. Canal Ct. Ste 2500
Littleton, CO 80120
Main Office – 303-798-2196
Fax – 303-730-2418
TMS Office – 720-671-0533

New Patient Registration

Patient Name: _____

Date of Birth: _____

Social Security # _____

Identified Gender: ☐ M ☐ F Relationship Status: ☐ married ☐ single ☐ separated

Address: _____

City: _____ State: _____ Zip: _____

Relationship to responsible party: ☐ self ☐ spouse ☐ child ☐ parent ☐ guardian

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

E-mail: _____

Preferred Communication: ◯ Email ◯ Phone/Text ◯ Both

Preferred phone for Communication ◯ Home ◯ Cell ◯ Work

Communications to Receive: ◯ All communications concerning treatment ◯ Just apptreminders

Responsible Party Information – Parent or Guardian if Patient is a Child

Name: _____

Relationship to Patient: ☐ spouse ☐ child ☐ parent ☐ guardian

Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

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Insurance Information

Name of primary insured:_____

Insured's Social Security#: _____

Patient's relationship to insured: _____

Insurance ID #:_____ Group #: _____

Patient Information

Authorization: Payment is expected at the time of service. The practitioner reserves the right to refuse services if payment has not been received prior to the start of the session. If there is financial hardship, the client will discuss this with the therapist in advance to services being rendered, or as soon as such arises within the treatment process. The above information is warranted to be true. I agree to be responsible for the charges incurred. If insurance is available, I authorize release of information for the purpose of filing claims, and also authorize payments of benefits directly to A New Outlook Recovery Services and/or Colorado TMS Services.

Cancellation of appointments must be made 24 hours in advance to avoid a $150 failed appointment charge. If the client dose not notify of impending late arrival and fails to show up for an appointment within the first 20 minutes for talk therapy or 10 minutes for medication management of the schedule session, it will be considered a no show and the client's card on file will be charged accordingly for the full session rate. Insurance companies do not reimburse clients for missed sessions. Illness and emergencies will be evaluated on a case-by-case basis. This fee is due prior to the next appointment.

Signature:_____ Date:_____

Relationship to patient if not signed by patient:☐ spouse ☐ child ☐ parent ☐ guardian

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A New Outlook Recovery Services

Colorado TMS Services

Office and Appointment Policies

First and foremost, welcome! We look forward to working alongside you and your loved ones during your counseling experience. Below are a few highlights to assist you with your first appointment.

1. Before the initial appointment, print and complete the following forms. *Please fill them out in their entirety*. Read them carefully to be informed of what you are signing. Please have them ready ahead of your scheduled appointment time. Should you not be able to bring these Intake Forms with you, please contact us at 303-798-2196, *prior* to your arrival and the forms will be waiting for you in the reception area to fill out.
2. Please check in and wait in the reception area until we come for you at your scheduled appointment time. There are several therapists in session throughout our hallway during the day. Doing this ensures profession respect and privacy for their clients.
3. Payments/Co-Pays are collected at the *beginning* of each session. Checks, cash, and credit cards are accepted.
4. All sessions are with therapists are forty-five minutes in length. Initial appointments with **Dr. Arshad William, MD or Michelle Quisenberry, PMHNP, RN, APN** are 45-60 minutes in length and follow-up appointments are 25 minutes in length. A wrap-up typically begins a couple of minutes before the end of our time together. This is usual and customary and abides with the ethical standards of the therapeutic process and guidelines. Appointments begin at the scheduled time. If a client arrives late, the session will be that much shorter. Conversely, if we are running late, the session will begin when the client enters the counseling office. **If patients for Dr. Arshad William, MD or Michelle Quisenberry, PMHNP, RN, APN are more than 10 minutes late, your appointment will be canceled and a fee of $150 will be charged to the patient. Therapy appointments are held for twenty minutes past your scheduled time. If a patient is more than 20 minutes late, the appointment will be canceled and a fee of $150 will be charged to the client, not the insurance company. If a client is a "No Show" or does not cancel the appointment 24 hours prior, the client, not the insurance company, is responsible for the payment of $150.**
5. The National Board of Certified Counselors (NBCC) prohibits counselors from "friending" or communicating with clients through all social media.

Again, welcome to our practice. We look forward to seeing you soon.

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Patient Intake

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment/copay at the *beginning* of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I also understand if I do not give a 24-hour cancellation notice, I am responsible for the full payment, not my insurance company, of $150.00 for the missed session.

CLIENT/GUARDIAN SIGNATURE **DATE**

I hereby consent to treatment by A New Outlook Recovery Services and/or Colorado TMS Services. Although the chances for obtaining my goals for therapy will be best met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop. I will not engage in the use of mind-altering substances prior to sessions; I will not bring any weapons of any kind to sessions.

CLIENT/GUARDIAN SIGNATURE **DATE**

I hereby authorize the release of necessary medical and/or billing information for client reminder calls, insurance reimbursement, and/or collection purposes to A New Outlook Recovery Services and/or Colorado TMS Services.

CLIENT/GUARDIAN SIGNATURE **DATE**

I authorize the payment of medical benefits to A New Outlook Recovery Services and/or Colorado TMS Services

CLIENT/GUARDIAN SIGNATURE **DATE**

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Staff:

Dr. Arshad William, MD

Dr. Richard Wallis, PhD, PMHNP

Robert J. Johnson, SAP, MAC, LAC

Paul Lovato, CAC III

James Weiss, CAC III

Clients are entitled to receive information about the methods of therapy, the techniques used; the duration of therapy (if known) and the fee structure. A client may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy between client and therapist is inappropriate and should be reported to the department of regulatory agencies: Department of Regulatory Agencies, 1560 Broadway, Suite 1340, Denver, Colorado 80202. Phone: 303.894.7766

What You Can Expect from Counseling: If you sincerely desire to work on your concerns and conflicts with yourself or others and believe that you have the capacity to do so, then we can work effectively together in counseling. A counselor cannot resolve problems. It is our responsibility to help you identify your beliefs and feelings, conflicts, and challenge inconsistencies, explore new choices and be supportive of your efforts to make changes that you want to make in your behaviors, feelings or responses to others. It is important that you prepare prior to each session by completing any assigned therapy tasks, or "homework", between sessions and be prepared to discuss.

Privileged Communication: Generally speaking, the information provided by and to a client during therapy session is legally confidential. There are exceptions to the general rule of legal confidentiality. The information provided by the client during therapy session is legally confidential, except as provided in section 12.43.218 and except for certain other legal issues. These include: a) Potential danger to self or others, b) Notes or summary of care is Court ordered, c) Clients of military status may be more susceptible to open information to reach the therapist in the future for services if needed.

Appointments: Therapy sessions are usually made on a regular schedule, although sometimes more visits will be beneficial. The therapy hour is 45 minutes, and we try to stay on schedule. If you suspect you may be late, please call ahead, as the session will be canceled after 20 minutes, and will be considered a failed appointment. Medication management appointments are 25 minutes and will be cancelled after 10 minutes, and will be considered a failed appointment. In the event that there is not a scheduled termination of the counseling relationship and the therapist has not seen the client in the past 90 days (for therapy clients) or 120 days (for medication management clients), the therapist will contact the client via their preferred method of contact once to inquire if the client wishes to continue the therapeutic relationship. This message will advise of the timeframe for scheduling to remain an active client and will explain how to reach the therapist in the future for services if needed.

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If no appointment is scheduled within the designated timeframe as identified or agreed upon, the client's chart will be closed. This action terminates the therapeutic relationship. Any unpaid balances on the client's account will be billed to the card on file, regardless of how termination arises Cancellations: When appointments are forgotten or canceled without a 24-hour notification, the client, not the insurance company, is responsible to pay the fee of $150.00.

Cancellations: When appointments are forgotten or canceled without a 24-hour notification, the client, not the insurance company, is responsible to pay the fee of $150.00. Clients who are chronically absent will be referred to other agencies. Accounts go to collections at 90-days past due. In the event of office closures due to inclement weather, you will be contacted either by the office administrator or your therapist via your preferred method of contact in order to cancel and reschedule your appointment.

Confidentiality: Your sessions are considered legally as privileged communications and are therefore protected as private with the exception referred to above or when using insurance, confidentiality is in a manner with your PPO or HMO agreement. If you need to have records made available to other professionals, a Release of Information Form will need to be signed. All written information provided to the courts OR other sources require notice ahead of time and a $75.00 per page fee will be charged. Anytime the therapist is called to court, a $2000.00 retainer fee is required up front. The fee for court is $225.00 per hour which includes travel time as well as time spent at the court.

Emergencies: In emergency situations or after hours, call 911 or go to a hospital emergency room.

Payment: At this time, we accept cash, check, or major credit cards. Payment/co-payment is due before each counseling session begins.

Client Signature (or guardian if client is a minor) _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW BEHAVIORAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present, or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon requires, or providing one to you at your next appointment.

A. HOW WE MAY USE AND DISCLOSE BEHAVIORAL HEALTH INFORMATION ABOUTYOU:

1. **For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of scheduling, providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.
2. **For Payment.** We may use or disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.
3. **For Health Care Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or PHI with third parties that perform various business activities (e.g. billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

4. **Required by Law.** We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures to public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful processes; disclosures for research when approved by an institutional review board; and disclosures to military or nation security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.
5. We may also disclose PHI for the purpose or reminding our clients of their appointments, sending them information about treatment alternatives or other health related services, disclosure to family member or other persons involved in our client care.
6. **State law requires us to obtain your authorization to disclose your health information for payment purposes.**

Without Authorization: **Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:**

1. **Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department).**
2. **Required by Court Order**
3. **Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious and imminent threat it will be disclosed to a person or persons reasonable able to prevent or lessen the threat, including the target of the threat.**

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization:

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Verbal Permission. **We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.**

Written Authorization. **Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked by you at any time. These authorizations include:**

1. **Psychotherapy Notes**
2. **Marketing Communications**
3. **Other disclosures such as insurance companies, schools, or attorneys.**

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Laura J. Wagner-Johnson at 1510 W. Canal Ct. Ste 2500, Littleton, CO 80120.

A. **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

B. **Right to Amend.** If you feel that the PHI, we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

C. **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

D. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes for carrying out payment of health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

E. **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

F. **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

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COMPLAINTS

If you believe that we have violated your privacy rights, you have the right to file a complaint in writing with The Colorado Department of Regulatory Agencies, Mental Health Section, at 1560 Broadway, Suite 1350, Denver, CO 80202, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington,
D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is August 1, 2019. We may change the terms of this notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice.

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Notice of Privacy Practices Receipt and Acknowledgement of Notice

Patient/Client Name: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of A New Outlook Recovery Services and/or Colorado TMS Services.

_____ _____
Signature of Patient/Client **Date**

_____ _____
Signature of Parent, Guardian, or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, guardian, healthcare surrogate, etc.).

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CREDIT CARD AUTHORIZATION

Name on authorized credit card: _____

Credit card #: _____

Exp Date: _____ CVC Code: _____

Billing address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, authorize A New Outlook Recovery Services and/or Colorado TMS Services to charge my credit card $150 for a failed appointment which includes missing a scheduled appointment without notice or with less than 24-hour notice. Unpaid balances upon discharge from the practice will be charged to my credit card. I understand that declined charges may result in loss of scheduling privileges or discharge as a patient from the practice.

Signature: _____ Date: _____

Printed name: _____

Colorado TMS Intake Form

1510 W. Canal Ct. Ste 2500
Littleton, CO 80120
303-798-2196

Client name & Date of birth: _____

At approximately what age did you develop depression? _____

When did the current episode of depression begin (Month & Year)? _____

Have you ever been diagnosed with Major Depressive Disorder? If so, by whom? _____

Have you ever had TMS treatment? ☐YES ☐NO If yes, please list when (month & year) and where you received treatment: _____

Have you ever had ECT (electroconvulsive therapy)? ☐YES ☐NO If yes, please list when (month & year) and where you received treatment: _____

Do you have any metal implants or stimulators in or around your head? ☐YES ☐NO

If yes, please specify: _____

Do you have any of the following psychiatric diagnoses? Please check if yes.

☐ Bipolar Disorder ☐ OCD ☐ PTSD ☐ Generalized Anxiety Disorder

☐ Substance Use Disorder ☐ Schizophrenia ☐ Eating Disorder

Do you have any neurological disorders, such as: ☐ Epilepsy ☐ Seizure Disorder
☐ Parkinson's Disease ☐ Dementia

Do you currently have, or have you previously had a therapist or counselor? ☐YES ☐NO

If yes, Name & Phone: _____

Location: _____

How often do/did you attend sessions? ____ times per week ____ times per month

Start & End dates of therapy: _____

Reason for stopping therapy? Ineffective ☐ Financial reasons ☐

Other (please specify) _____

Are you currently taking or previously taken antidepressant medications? ☐YES ☐NO

If yes, please list provider(s) who prescribed medications & contact information: _____

Are you currently planning on taking a vacation or missing any daily treatments during the next 3 months? □YES □NO

If yes, please give us some more information: _____

Please indicate any of the following antidepressants that you have been prescribed either currently or in the past. This information is required for prior authorization from most insurances.

Medication	Dose	Start/End Dates (Month & Year)	Effectiveness, side effects, etc.
Abilify (aripiprazole)			
Celexa (citalopram)			
Cymbalta (duloxetine)			
Effexor (venlafaxine)			
Elavil (amitriptyline)			
Lamictal (lamotrigine)			
Lexapro (escitalopram)			
Luvox (fluvoxamine)			
Pamelor (nortriptyline)			
Parnate (tranylcypromine)			
Paxil (paroxetine)			
Pristiq (desvenlafaxine)			
Prozac (fluoxetine)			
Remeron (mirtazapine)			
Risperdal (risperidone)			
Sinequan (doxepin)			
Surmontil (trimipramine)			
Tofranil (imipramine)			
Viibryd (vilazodone)			
Wellbutrin (bupropion)			
Zoloft (sertraline)			
Zyprexa (olanzapine)			
(Other)			
(Other)			

Printed name: _____

Signature: _____ Date: _____

A New Outlook Recovery Services & Colorado TMS

Office #: (303) 798-2196 Fax #:(303) 730-2418 1510 W. Canal Ct. Ste 2500 Littleton, CO 80120

I, _____ hereby authorize:

Client Name and Date of Birth

Agency or Individual	**Address**	**Phone or Fax #**

To release the following health information about me, TO: A New Outlook Recovery Services/Colorado TMS: (Please check appropriate boxes)

No	Yes	
☐	☐	Name and/or phone number
☐	☐	Demographic information (age, sex, ethnicity, address, etc.)
☐	☐	Diagnosis(es)
☐	☐	History and/or Physical
☐	☐	Laboratory results: _____
☐	☐	Psychological/Psychiatric evaluation summary: _____
☐	☐	Billing/Financial information
☐	☐	Progress Report/Treatment Summary/Family Therapy Summary
☐	☐	Urinalysis/Breathalyzer results record
☐	☐	Other (Specify): _____

**Information contained psychotherapy notes may not be released by this authorization. A special authorization must be obtained.

The information is required for: (Please check boxes that apply, if "Other" is checked, you *MUST* describe the purpose forinformation being provided.

☐	Treatment (to obtain additional)	☐	Court for:_____
☐	Consideration/Maintenance of Employment	☐	School, eligibility, credits
☐	Probation/Parole, ongoing eligibility	☐	Voc Rehab, initial and ongoing eligibility
☐	Social Services, to obtain eligibility for treatment	☐	Family members, to inform them of my care and treatment
☐	Other: (Specify):_____		

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Part 160 &164, and cannot be disclosed without my written permission unless otherwise provided for by the regulations I also understand that I may revoke this permission in writing at any time (refer to your copy of the HIPAA Notice of Privacy Practices for information on how to revoke this permission) except to the extent that action has been taken in reliance on it, and that in any event this permission expires automatically on the date written below:

_____

Date (2 Years)

I understand that generally, A New Outlook Recovery Services., may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances, I may be denied treatment if I do not sign an authorization form. For example, if funding for my treatment is contingent on the agency providing the funding receiving reports on my progress in treatment, I may be refused treatment funded by that source if I am unwilling to consent to release progress reports. I also understand that the people who get this information may give out my information, and it may no longer be protected. However, A New Outlook Recovery Services, will try to prevent redisclosure of my information by providing notification of prohibition of redisclosure to those receiving my information. I understand that I will be given a copy of this permission once I have signed and dated it.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Authorized Representative (Describe relationship) Date

_____ _____

Witness Date

(Send original if requesting information from another party. Send copy if releasing information to another party. Send copy ifinformation requested from A New Outlook Recovery Services, LLC., by another party.) *01/2011*