

Sharona Stone, MEd, LCSW, DCH

DISCLOSURE INFORMATION

Professional Education

DCH – Doctorate in Clinical Hypnotherapy from American Institute of Hypnotherapy, Irvine, CA
(Currently affiliated with American Pacific University)

Post-graduate Certificate of Advanced Professional Studies – in Marital and Family Therapy, Family Therapy (AAMFT Approved Training Program) University of Denver, Graduate School of Social Work

MSW – Masters in Clinical Social Work, University of Denver, Graduate School of Social Work
Internships: George Washington High School, Denver and Aurora Community Mental Health Center

MEd – Masters in Child Development, Tufts University, Medford, MA

License: Licensed Clinical Social Worker, Colorado License #989449

Regulation of Mental Health Professionals in Colorado

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing section of the Division of registrations.

The regulatory requirements applicable for the various mental health professionals are:

A **Licensed Psychologist** must hold a doctorate degree in psychology and have one year of post-doctoral supervision as well as pass a professional licensing examination in their field.

A **Licensed Clinical Social Worker (LCSW)** must hold a master's degree in social work and have two years of post-master's supervision as well as pass a professional licensing examination in their field.

A **Licensed Marriage and Family Therapist (LMFT)** must hold a Masters in a mental health discipline with a specified number of courses in marital and family therapy and have two years of post-masters supervision as well as pass a professional licensing examination in their field.

A **Licensed Professional Counselor (LPC)** must hold a Masters in counseling and have two years of post-masters supervision as well as pass a professional licensing examination in their field.

A **Psychologist Candidate**, a **Marriage and Family Therapist Candidate**, and a **Professional Counselor Candidate** must hold the necessary degree required for licensing in their discipline and be in the process of completing the required supervision hours, for licensing.

A **Certified Addiction Counselor I (CAC I)** must be a high school graduate, and complete the required training hours and 1,000 hours of supervised experience.

A **Certified Addiction Counselor II (CAC II)** must complete additional hours of required training and have 2,000 hours of supervised experience.

A **Certified Addiction Counselor III (CAC III)** must have a Bachelors in behavioral health, and complete additional training hours and have 2,000 hours of supervised experience.

A **Licensed Addiction Counselor** must have a clinical Masters and meet the CAC III requirements.
(Over)

A **Registered Psychotherapist** is registered with the State Board of Registered Psychotherapists, and is not licensed or certified, and no degree, training or experience is required.

Your Rights

Psychotherapy or counseling cannot be easily described in general terms, 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 may seek a second opinion from another therapist or terminate therapy at any time.

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.

The information that you 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 12-43-218 of the Colorado Revised Statutes and the HIPAA, Notice of Privacy Practices that have been provided for you as well as other exceptions in HIPAA, Notice of Privacy Practices that have been provided for you as well as other exceptions in Colorado and Federal laws. For example, mental health professionals are required to report child abuse to the authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

As a Licensed Clinical Social worker, my practice is regulated by The Board of Social Work Examiners and can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894.7800.

Statement of Understanding

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

Client or responsible party’s signature

Date

If you are the responsible party, state your relationship to client, and authority to consent.

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FEE AGREEMENT

Please read carefully, there is important information on this form. Your signature at the bottom attests to your understanding of the business practices and fee policies in this practice.

ATTENDANCE

At the outset of therapy, I encourage weekly sessions whenever possible. Less frequent sessions may be scheduled after the first 2-3 sessions. Therapy is a collaborative process that requires commitments of time and energy, in sessions and practice between sessions.

STANDARD FEES

The fee for an initial appointment or consultation (50-60 minutes) is \$120. The charge for subsequent sessions (45-50 minutes) is \$100. If I have applicable health insurance, and opt to use this, my insurance will be billed in accordance with these standard fees; and contracted rates will apply.

PAYMENT

Payment is accepted by check or cash, and expected at the time of each session. If, for any reason payment is not made at this time, a \$10 **processing fee** will be added to your account (unless other arrangements are made to bring your account current within 7 days).

COPAYMENTS

Almost all insurance plans require that you make a Copayment to the Provider at the time of service.

DEDUCTIBLES

In many cases, insurance plans have a deductible and require that you pay a certain amount of expenses before they will pay any claims. Until your deductible has been met you are responsible for all charges (per the contracted rate of your health benefits plan with this provider).

INSURANCE

When **utilizing health insurance to pay for services**, you are financially responsible for any copays/coinsurance/deductible (if not previously met), and payments are due at the time of your session.

I am an in-network provider with many companies although not all. Prior to your first appointment, you may want to contact your insurance company to verify your outpatient benefits. While I will also attempt to verify your coverage and financial responsibility, due to privacy laws some companies will not disclose this information to a provider before a patient is seen, and signed a written consent.

Please be aware insurance companies quote benefits; however, a disclaimer is cited: "Benefits quoted are not a guarantee of payment, and all claims are subject to review and determination of medical necessity." If claims are denied or paid less than anticipated, you acknowledge and accept full responsibility for differences (per terms of provider's contract, and active coverage at time of service).

***UNPAID INSURANCE CLAIMS**

If for any reason your insurance delays payment beyond 60 days from the date of submission, you are financially responsible for any outstanding balance. Should insurance subsequently pay then

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adjustments or refunds will be made accordingly. In cases of nonpayment by insurance you will receive a Statement that documents to date all unpaid dates of service. Payment is due in full at this time on your outstanding balance (to be paid no later than 7 days from statement date). If this poses a financial hardship, a payment plan will be considered with the understanding the unpaid balance will begin accruing interest at 1.5% monthly; and if installments are not kept current then a \$10 monthly rebilling fee will apply.

GENERAL BILLING

Billing is not routine since payment is expected at the time of service. If for any reason there is an outstanding balance on your account, you will be sent a Statement that balance is due within 14 days from the Statement date.

Late payment status occurs when there is an outstanding balance for over 30 days from the date of the last session. Accounts in **late payment status** are subject to a monthly **rebilling fee of \$10** and the unpaid balance will accrue interest at the rate of 1.5% monthly (18% annually).

OTHER FEES (Pro-rated at the hourly rate of \$100):

- Contact between sessions: extended telephone calls (over 5 minutes); and/or multiple emails or texts (utilized in place of scheduling a session).
- Communication with other professionals (written or telephonic).
- Requests for letters, reports, or completing paperwork for third parties.
- Returned check fees, or credit card denials (NSF charges incurred + \$10 administrative fee).

PAYMENTS FOR CHILDREN'S SERVICES

In the case of children and divorced parents, regardless of your parenting agreement and allocation of payment for medical expenses, the parent bringing the child is fully responsible for all applicable fees that are due on that date of service (all financial adjustments are between the parents and not with this provider).

FSA (FLEXIBLE SPENDING ACCOUNTS) or HSA (HEALTH SAVINGS ACCOUNT)

If you have an FSA OR HSA, you may be able to pay using a designated checking account. I am unable to accept HSA credit card payments.

CANCELLATION POLICY

The business and appointment cancellation policies require that you provide **AT LEAST 24 HOURS NOTICE** if you need to cancel, change or reschedule an appointment.

Monday appointments require notification be given on Fridays before 11 am (to allow sufficient time for scheduling another client). If cancellation occurs **less than 24 hours in advance** you will be billed for the full amount of the scheduled session. Please be aware that health insurance companies do not cover the cost of missed appointments, and therefore you will be responsible for the full fee (not the copayment amount). In cases of true emergencies, and at times last minute work demands may factor in; and therefore, I offer the following:

OPTIONS FOR AVOIDING CANCELLATION CHARGES

1. Requesting a telephonic session instead of in the office (to occur at the time of the session, the same day, or within the same week).
2. Rescheduling the session in the same week at another available time.

COURTESY AND CONSIDERATION ARE MOST APPRECIATED by this provider and other patients seeking appointments.

RETURNED CHECK FEE

For any NSF or denied payments fees will be assessed to your account in accordance with charges incurred by this provider.

UNSETTLED ACCOUNTS

Delinquent account status applies when no payments have been made for 60 days. The account is considered in *default*.

COLLECTIONS

This is a last resort, referring an account to Collections. In the event, a client has been unable or unwilling to develop or honor a payment plan, the account will be referred to United Resource Systems, a Collection agency. A Collection Fee in the amount of \$50, or 30% of the referred balance, whichever is greater will be assessed to the account. In the event the collection agency initiates legal action to collect the amount due, I understand I will be responsible for all court costs, and reasonable attorney fees incurred to enforce this agreement.

* Please note, a statutory limitation on confidentiality applies to the collection of fees, and nonpayment qualifies as a waiver of this privilege.

ATTORNEY FEES/COURT COSTS

I understand that any lawsuit by the Collections agency over the terms of this agreement shall be brought within the courts of Colorado and governed by the laws of this state. Accordingly, the parties hereby subject themselves to the jurisdiction of those courts. Should a dispute result in any term being declared contrary to those laws, the remaining terms shall still be binding. The losing party will pay all reasonable and necessary costs (including attorney fees) of any lawsuit to enforce this agreement.

Signature: _____ Date: _____

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INSURANCE CONSIDERATIONS

USING INSURANCE BENEFITS OR OPTING OUT

While I accept many insurance plans (contracted rates apply), I am not in network with all companies. If I am an out-of-network provider, you are responsible for paying the standard fees at the time of service.

Please be advised if you choose to utilize insurance benefits I am required to provide a diagnosis that will establish the medical necessity for these services. In some cases, clients may prefer not to have a diagnosis on file with their insurance company, and can choose to pay out-of-pocket. Payment from an HAS may require additional documentation to support payment was made for medical expenses.

PLEASE CHECK ONE:

OPTING OUT OF USING INSURANCE BENEFITS:

I am planning to pay privately for therapy, either because you are a provider not in my network, or I have chosen to not have a diagnosis reported to my insurance company. I am agreeing to be a **Self-Pay client**; the standard fee of **\$120 (intake/first session) and \$100 per therapeutic hour (50-60 minutes)** applies.

UTILIZING INSURANCE BENEFITS:

I am planning to use my insurance benefits, and understand you will be submitting a diagnosis with claims. Further, I understand you may be required to provide additional information for purposes of care management or case review. Understanding this, I have filled out an Insurance Data Form consenting to your release of information.

The check mark above indicates your authorization for direct payment to the provider by your insurance (this pertains to their responsibility only, and you are responsible for your portion of fees).

If you decide later to change your payment status from Self-Pay to billing insurance, you will need to complete a new Fee Agreement, effective only for future sessions, and this must be sent via email to: sharona@drsharona.com.

CHANGES IN INSURANCE COVERAGE

Most commonly insurance enrollment and plan coverage is based on the Calendar Year requiring (when applicable) a new deductible becomes effective January 1 and must be met again each new calendar year. In some cases, insurance enrollment and plan coverage occurs during a different calendar quarter i.e., April 1, July 1, or September 1. It is **your responsibility to notify this provider of any changes in your insurance coverage.**

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PRIMARY INSURANCE INFORMATION

Patient's name: _____

Date of birth: _____

Insured's name: _____

Insured's date of birth: _____

Insured's address: _____

Insured's employer: _____

Employment address: _____

Member ID: _____

Group: _____

Name of insurance company: _____

Claims address: _____

Customer Service telephone: _____

Signature: _____ Date: _____

*If you have secondary insurance coverage, please print a second copy of this page, and label it Secondary Insurance.

(Revised 10.09.17)