RESPARK FOUNDATION

Office Number: (303) 900 - 3087 | **Office Email**: contact@resparkfoundation.org
Respark Mailing Address: 12081 W. Alameda Pkwy Suite 404,
Lakewood, Colorado 80228

Texas Services: Online throughout the state, physical office in Austin and San Antonio
Colorado Services: Currently Online Only
Online Teletherapy: Your therapist will reach out to you via email with a link to your session

Welcome to the Respark Foundation!

We are so glad you're here and we look forward to working with you.

The Respark Foundation is a 501(c)3 non-profit.
We honor ourselves and the community by providing a high level of care in sex therapy, sexual trauma, emotional trauma, and the intersection of how they affect you in your daily life within yourself and in your relationships. Our therapists and coaches receive the highest level of sex informed and trauma training, they are ready to assist in you becoming the best version of you.

Please review the following material, complete all forms, and upload them to our online portal. Feel free to send the forms via email as well if you have trouble uploading them.

Respark Foundation

This welcome packet includes several documents:

1. **Informed Consent for Psychotherapy**
   - This section describes Respark's policies and our commitment to maintaining client confidentiality.
2. **Credit Card Authorization Form**
   - This form is used for the purpose of late cancellations and/or not showing to a scheduled appointment. In addition, this form is used when a third party is responsible for payment, and the client will not have the physical card at each session. In that case, the third party responsible for payment must sign the credit card authorization form.
3. **Client Information/Questionnaire**
   - This section contains client demographic information, health history, and details about the issues for which you are seeking support at this time.
4. **Notice of Privacy Practices**
   - This section explains the current ethical guidelines and regulations and requests your signature to confirm your understanding of these regulations.
5. **Out-of-Office Confidentiality**
   - This form discusses the limitations of confidentiality through out-of-office forms of therapy including telehealth sessions, phone sessions, and walk and talk therapy sessions. It also includes the client(s) responsibility to assure a confidential setting on their behalf and requests your signature to confirm your understanding that these sessions are not a fully secure medium.
6. **Release of Information**
   - This form is a release to disclose protected health information to a person or organization of your choosing. You will only need to fill this out if you wish for your therapist to communicate with someone outside of the agency.

INFORMED CONSENT FOR PSYCHOTHERAPY

Privacy and Confidentiality:

All interactions with your therapist including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your **records are *confidential as required under Texas & Colorado state law***. Your privacy is extremely important to us. Accordingly, you may discuss this several times with your therapist. Please feel free to **ask questions for clarification**. There are ***some limits to confidentiality***, and they include the following:

Exceptions to Confidentiality:

- If there is ***imminent danger*** or harm to ***yourself and/or others***.
- If your therapist has reason to believe that you are involved in or have knowledge of ***abuse or neglect of a child***, or ***abuse or neglect of a person who is elderly or has a disability***.
- A ***court order*** or subpoena.

Supervision and Consultation:

Some of our ***postgraduate therapists or interns and practicum students work under the supervision or consultation of Respark Founder, Heather McPherson, M.A., LPC-S, LMFT-S, CST-S.*** Within the practice, we may discuss therapeutic work for the purposes of consultation. In addition, we may occasionally consult with other professionals in their areas of expertise in order to provide the best treatment for you. This is an established practice in the field of psychotherapy and is beneficial to your treatment. During consultation, ***we keep identifying information such as names confidential.***

Interactions Outside of the Office:

If we see each other accidentally outside of the therapy office, I will ***not*** acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if ***you acknowledge me first***, I will be more than happy to ***speak briefly*** with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Acknowledgements: I, ____ (client's name(s)), understand the limits of confidentiality as stated above and accept them as part of the conditions for receiving services at Respark.

Client Signature: ____ **Date:** ____________

Client Signature: ____ **Date:** ____________

The Therapeutic Process:

We view therapy as a combination of self-discovery and learning new ways to exist in your environment. Your work will entail learning new personal and interpersonal skills/strategies. The process can be uplifting and motivating as well as uncomfortable and tiresome. Through practice, things can shift to feel better. Different amounts of time are required depending on the issue of concern. Long-lasting change sometimes requires a significant time investment. This process is meant to improve relationships, communication, and productivity in one's life, while helping you live more authentically. It is our goal to create a non judgmental, compassionate and positive counseling experience that allows for this growth to happen.

Billing And Payments:

The fee for psychotherapeutic services is based on your therapist's rate, unless otherwise discussed. ***Fees for services are billed 48 hours prior to your scheduled appointment day to the credit card we have on file***.

- ***Notice of cancellations are required at least 48 hours in advance of your scheduled appointment***. Should you fail to provide this notice, you will be ***charged for the full session's fee***.
- In the case of **emergency cancellations where 48 hours notice cannot be provided**, please contact your therapist and/or the Care Team (care@respark.co) so they can assist you with rescheduling or issuing a refund.
- Phone calls exceeding 15 minutes, any professional consultations necessary for your care, requested letters, or other services will be ***prorated***.
- ***Court appearances or involvement*** will be charged **$250.00 per hour** including documentation writing/gathering and any travel time and expenses incurred.
- If the fee for services is altered, you will be informed in writing.

Operational Policies:

Sessions are conducted for ***45 to 50 minutes*** unless otherwise specified by your therapist. If additional time is requested, you will be charged a prorated fee. It is expected that sessions ***begin and end promptly at the agreed upon time*** so as not to impact the appointments of other clients. If you ***arrive late for an appointment***, we will need to ***conclude the session within the scheduled time***. The time will be ***billable for the full session's fee***. Additionally, if you are ***going to be more than 10 minutes late for your scheduled session***, please ***email and/or text your therapist*** to let them know so that they do not leave the call and bill you for the session as a 'no show.'

If due to ***illness or emergency***, you are **unable** to make your scheduled appointment, please call to ***cancel as far in advance as possible***.

Please note that ***email and text message communication with your therapist*** is ***reserved specifically*** for ***scheduling purposes ONLY***.

If you are experiencing a state of crisis or emergency, we recommend that you contact crisis intervention services for your local area:

- ➔ **Immediate Help**:
  - ◆ **Life-threatening Emergency**
    - ● Call 911
  - ◆ **Mental Health Crisis or Thoughts of Suicide**
    - ● National Suicide Prevention Lifeline
      - ○ 1 (800) 273-8255
      - ○ TRS: 1 (800) 799-4889

- ➔ **Crisis "TEXT" Line**:
  - ◆ Text "HEAL" to 741741
- ➔ **If you're UNDER 21, you can call "Teen Link"**:
  - ◆ 866-TEENLINK or (866) 833-6546
  - ◆ Phone Line is open 6pm-10pm and Chat is available 6pm-9:30pm daily

Texas Crisis Lines:

Austin Travis County Integral Care Crisis Hotline…………………………512-472-HELP (4357)

Colorado Crisis Lines:

Colorado Crisis Services…………………………………………………..1-844-493-TALK (8255)
or text "TALK" to 38255

Suicide & Crisis Lifeline………………………………………………………… Text or Call 988

Client Rights:

As the client, you are in control of your therapeutic experience. You may choose to end therapy at any time. If you ever have any questions during the course of therapy regarding the direction and process of your treatment, please raise those questions with your therapist. If you are unhappy with the process or wish to change directions, you have the right to request a change. If at any time you feel your therapist is not the best fit for you, please let him/her/them know and they will be happy to assist you in finding the right therapist for you. In addition, you can reach out to Respark's clinical manager, at care@respark.co for any concerns or utilize our Respark feedback form.

Termination:

Ending relationships can be difficult. Therefore, it is important to have a termination process in place in order to achieve closure. As a client, you have the right to terminate services at any time. Respark will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. Respark also has the right to terminate the therapeutic relationship at any time. Termination may occur if the therapist feels the therapeutic relationship is no longer beneficial or if you are in default of payment. If therapy is terminated for any reason or you request another therapist, Respark will provide you with a list of qualified therapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for four consecutive weeks, unless discussed prior and other arrangements have been made in advance for scheduling, for legal and ethical reasons, Respark must consider the professional relationship discontinued. You are welcome to reach out again in the future, if you decide that you would like to begin therapy again at a later date. Client files will be stored according to state license board rules.

Acknowledgements: I, ____ (client(s) name), have reviewed the policies and procedures detailed in this informed consent document. I have asked for all needed clarifications. I am satisfied by the explanations and agree to adhere to these policies. I willingly consent to participate in counseling with the therapist listed above. I understand that I may withdraw my consent at any time and terminate my services at will.

Client Signature: ____ Date: _____________

Client Signature: ____ Date: _____________

PAYMENT AUTHORIZATION FORM

Client Name: ____ **Date**: ___________

Financially Responsible Party: ____

Please Check: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Name on Card: ____

Card Number: ____________________________________ **CVC:** __________

Expiration Date: _____________ **Is this an HSA Card?** Yes / No

<u>BILLING ADDRESS</u> (for the card above):

Street Address: ____

City: _________________________ **State:** ___________ **Zip Code:** _____________

By signing below, I acknowledge that the information provided above will be utilized within the financial policies outlined in the informed consent contract of Respark, PLLC. I understand that I can revoke my authorization at any time. This information will be kept confidential and will be utilized for the purposes of maintaining good financial standing with Respark, PLLC.

Signature of Cardholder: ____

Date: __________________

You are able to change your payment information at any point by contacting our Care Team at care@respark.co or (512) 537-0922

CONFIDENTIAL CLIENT INFORMATION FORM

Legal Name: ____

How would you like to be addressed by the therapist? ____________________

Age: _____ **DOB:** ____ / ____ / ____

Partner's Name: ________________________ **Age:** _____ **DOB:** ___ / ___ / ___

Partner's Name (List all additional partners if applicable):

____

Age: _____ **DOB:** ___ / ___ / ___ **Age:** _____ **DOB:** ___ / ___ / ___

Street Address: ____

City: ___________**State**:__________________ **Zip Code:** ________________

Phone:_________________________**May we leave a message?:** YES / NO

Email Address (If we may contact you via email)**:** ____________________________

Occupation(s) & Employers: ____

Highest Level of Education Completed:__________________________________

How did you find us? (Please Check)

FRIEND PSYCHOLOGY TODAY
WEBSITE GOOGLE AD THERAPY DEN
MEDICAL DOCTOR THERAPIST
OTHER: ___________________

Respark Foundation

If you were referred by another therapist, may we have your permission to thank them?

Please check: YES / NO
Therapist's Name *(if applicable):* ____

RELATIONSHIP(S):

____ SINGLE ____ DATING ____ MARRIED
____ DIVORCED ____ SEPARATED ____ COMMITTED RELATIONSHIP
____ ENGAGED ____ LIVING TOGETHER
OTHER: ________________________________

Sexual Orientation:____
Religion/Spirituality:____
Gender Identity:_______________ **Preferred Pronouns:**_____________

Race/Ethnicity:____

Additional important relationships or family members:

CLIENT QUESTIONNAIRE

1. Please briefly describe the concern for which you are seeking counseling at this time:

2. Have you and/or your partner(s) ever seen a therapist or mental health professional before or are you seeing a therapist currently? If yes, was (or is) it helpful?

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3. Have you and/or your partner(s) previously been given any mental health diagnoses or neurodivergent (i.e. ADHD, autism spectrum)? If yes, please describe:

4. What medications, herbs/supplements, and/or recreational drugs, if any, are you and/or your partner(s) currently using?

5. Do you experience any sensory sensitivities (i.e.smell, audio,)?

CONFIDENTIAL CLIENT INFORMATION FORM

COUPLES THERAPY ONLY

(If you are seeing us for couples therapy, there is space, above, for one partner and space, below, for another you each will need to complete your own form)

Legal Name: ____

How would you like to be addressed by the therapist? _____________________

Age: _____ **DOB:** ____ / ____ / ____

Partner's Name: ________________________ **Age:** _____ **DOB:** ___ / ___ / ___

Partner's Name (List all additional partners if Applicable):

____

Age: _____ **DOB:** ___ / ___ / ___ **Age:** _____ **DOB:** ___ / ___ / ___

Street Address: ____

City: ____________________ **State**: __________ **Zip Code:** ____________

Phone: _______________________ **May we leave a message?:** YES / NO

Email Address (If we may contact you via email)**:**

____

Occupation(s) & Employers: ____

Highest Level of Education Completed: __________________________________

How did you find us? (Please check)

____ FRIEND ____ PSYCHOLOGY TODAY
____ WEBSITE ____ GOOGLE AD ___ THERAPY DEN
____ MEDICAL DOCTOR ____ THERAPIST
OTHER: __________________

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If you were referred by another therapist, may we have your permission to thank them?

Please check one: YES / NO
Therapist's Name *(if applicable):* ____

RELATIONSHIP(S):

____ SINGLE ____ DATING ____ MARRIED
____ DIVORCED ____ SEPARATED ____ COMMITTED RELATIONSHIP
____ ENGAGED ____ LIVING TOGETHER
OTHER: ___________________________________

Sexual Orientation: ____

Religion/Spirituality: ____

Gender Identity: _______________________ **Preferred Pronouns**: ______________

Race/Ethnicity: ____

Additional important relationships or family members:

CLIENT QUESTIONNAIRE

1. Please briefly describe the concern for which you are seeking counseling at this time:

2. Have you and/or your partner(s) ever seen a therapist or mental health professional before or are you seeing a therapist currently? If yes, was (or is) it helpful?

3. Have you and/or your partner(s) previously been given any mental health diagnoses or neurodivergent (i.e. ADHD, autism spectrum)? If yes, please describe:

4. What medications, herbs/supplements, and/or recreational drugs, if any, are you and/or your partner(s) currently using?

5. Do you experience any sensory sensitivities (i.e. smell, audio)?

Respark Foundation

NOTICE OF PRIVACY PRACTICES

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.

Our Commitment to Your Privacy:

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care.

How We Can Use and Disclose Your Personal Health Information with Your Consent:

We will use the information we collect about you mainly to provide you with treatment and to arrange payment for our services. After you have read this notice, we will ask you to sign a consent form to allow us to use and share your information in these ways. If you do not consent and sign the form, we cannot treat you. If we want to use or send, share, or release your information for any other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your Health Information without Your Consent:

There are sometimes when the law requires us to use or share your information.
For Example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For some workers' compensation programs.

There may be additional reporting requirements of your therapist, based on the therapeutic ethical code. If you have any additional questions regarding this process, please ask your therapist.

Your Rights Regarding Your Health Information:

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment for your care such as family members and friends.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our clinical manager to arrange how to see your records.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to us. You must also tell us the reasons you want to make the changes.

5. You have a right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy from us.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the healthcare we provide in any way.

Finally, you may also have other rights that are granted to you by the laws of Texas & Colorado. These may be the same or different from the rights described above. We will be happy to discuss these situations with you as they arise. If you have any questions regarding this notice or our health information privacy policies, please ask your therapist.

Acknowledgement of Understanding of Privacy Notice

As a client, you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you understand Respark's Privacy Practices.

Client Signature: ______________________________________ **Date:** _____________

Client Signature: ______________________________________ **Date:** _____________

Respark Foundation

OUT-OF-OFFICE CONFIDENTIALITY

I acknowledge that Out-of-Office sessions:

- Telehealth Sessions: Doxy or Zoom
- Phone Sessions
- Walk and Talk Therapy Sessions

Are held with the understanding that the **client is solely responsible** for assuring a **confidential setting on their behalf**. The therapist will assure a confidential setting while utilizing telephone and internet technologies at the therapist's location.

In addition, the therapist will do their best to provide a confidential space during walk and talk therapy sessions (i.e.: keeping considerable distance from others in public, etc.). However, all of these methods of therapy are not fully secure mediums.

I agree that I will **NOT** be **under the influence of alcohol or other substances during the session**. It is my responsibility to make sure that I am in a safe place where I won't be interrupted to ensure my confidentiality.

Limitations of Telehealth Sessions:

While telehealth services offer several advantages such as convenience and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, the therapist might not see various details such as facial expressions. Or if audio quality is lacking, the therapist might not hear differences in your tone of voice that I could easily pick up if you were in the office. Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. Your therapist will take every precaution to insure technologically secure and environmentally private psychotherapy sessions.

Client Responsibility for Telehealth Sessions:

● Respark strongly suggests that you only communicate through a device that you know is **safe and technologically secure** (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.)

● Do not use "auto-remember" names and passwords. Make sure you have ***checked your company's policy before using a work computer for personal communication***.

● As the client, you are responsible for finding a private, quiet location where the sessions may be conducted. ***Sessions are not able to take place if other individuals are present in your location***. Consider using a "do not disturb" sign/note on the door or playing a sound machine / soundtrack to add background noise.

● For **safety reasons**, I agree that I will **NOT** be ***under the influence of alcohol or other substances during the session***. I agree that I will find a safe place to access my therapy sessions and will not be driving, on public transportation, or any moving platform (besides walking) during my telehealth session. It is my responsibility to make sure that I am in a safe place where I won't be interrupted to ensure my confidentiality.

● When utilizing telehealth therapy, I agree that I will **verify my location** with my therapist at the **start of the session in case of emergency**.

● I agree to set a protocol in place with my therapist when utilizing telehealth therapy in case of technology failures and/or difficulties. This can include using alternative platforms or switching to phone sessions.

My signature below shows that I understand and agree with all of these statements.

Printed Name: ____ **Date:** ____________

Client Signature:____

Printed Name: ____ **Date:** ____________

Client Signature:____

AUTHORIZATION TO RELEASE INFORMATION

Please be advised that mental health records constitute privileged information that is **protected by laws of the State of Texas & the State of Colorado** they may contain information that is **protected under Federal Confidentiality regulations**. These records ***cannot be disclosed without written consent unless otherwise provided for in Federal regulations***. Authorizing the release of information contained in mental health records constitutes a waiver of privilege. You may revoke this consent by written notice, but it will not apply to action that has been taken prior to receipt of the revocation.

This information is to be released to:

Person: ____

Phone Number: ______________________ or **Fax Number**: _____________________

Address: ____

<u>For the following purpose(s)</u>:

____ Further mental health treatment or care
____ Rehabilitation program development or services
____ Treatment planning
____ Research
____ Emergency Contact
____ Other: _______________________

These records concern the time between _______________ and ______________.

Client Name: ____________________________________ **DOB**: _________________

I have explained to me and fully understand this request/authorization to release records and information including the nature of the records, their contents and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

Client Printed Name: ____

Client Signature: _________________________________ **Date**: _________________