Section I-Patient Information

Last Name	First Name	Middle Initial	Gender/Preferred Pronouns

☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	Last 4 of SS# XXX-XX-	Date of Birth

Home Address City State Zip	Race/Ethnicity

Home Phone	Cell Phone	May we leave messages regarding appointments? Yes ___ No ___	Email Address

Current Employer	Occupation	Current Work Phone #

Current Employer's Address/Location	Interpreter Name/CO (if applicable)	Interpreter Phone #

Is this visit related to a **work** injury? Yes ___ No ___ If yes, date of injury: _____ and complete Sections II, V, & VI.
Is this visit related to an **auto** injury? Yes ___ No ___ If yes, date of accident: _____ and complete Sections III, V, & VI.
If this visit is **not** related to either of the above, please complete Sections V & VI, and initial/sign at the bottom (both boxes).

Section II-Worker's Compensation Information
(Must be completed in order to bill Worker's Compensation claims)

Employer at time of injury (if different from above)	Employer's address/City/State/Zip (if different from above)	

Insurance Company's Name	Claim/Subscriber Number	Main Phone Number

Name of Adjustor or Claims Representative	Adjustor's Phone	Adjustor's Fax

Name of Nurse Case Manager (if applicable)	Case Manager's Phone	Case Manager's Fax

Primary Claim Address/City/State/Zip	Primary Claim Phone

Section III-Auto Insurance Information
(Must be completed in order to bill Auto Insurance claims)

Insurance Company's Name	Insurance Company's Address/City/State/Zip	

Adjustor's Name	Adjustor's Phone Number	Claim Number

Section IV-Commercial (Primary) Insurance Information
(Please note: the Behavioral Medicine Center does not accept any Commercial Insurance plans at this time.)

Insurance Company's Name	Address City/State/Zip		Phone

Co-pay amount	Policy Holder's Last Name	First Name	Relationship

Type of Coverage (HMO, POS, PPO, etc.)	Group Number	ID or Member Number

Section V-Referral Source

Referred By	Referral Source Phone	Referral Source Fax

Section VI-Emergency Contact Information (Required for Telehealth)

Name	Phone	Relationship	May we contact this person in case of emergency? Yes_____ No_____

Authorization of Payment for Services: *Please initial one*

_____ If using insurance (including Work Comp): I authorize payment of benefits directly to the Behavioral Medicine Center for services provided by Rebecca Hawkins, PhD, PC.

_____ If not using insurance: I agree to pay at the time of service in accordance with the fee schedule I have been provided for services provided by Rebecca Hawkins, PhD, PC.

A photocopy of this authorization shall be as valid as the original.

X_____ _____

Signature Date

Authorization for Release of Records: *Please initial one*

_____ Work-Related Condition or Injury: I authorize the release of any medical or other information necessary to process claims pertaining to my occupational injury claim.

_____ Non-work Related Illness or Injury: I authorize the release of any medical or other information necessary to process claims for services provided. I also agree to pay all outstanding balances not covered by my insurance plan, as well as reasonable fees if my account is turned over to collections for nonpayment.

X_____ _____

Signature Date

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phone 303.830.1181
fax 303.830.0270

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Authorization for Electronic Communication

NAME:_____DOB:_____SSN: XXX-XX-_____

Electronic communication includes phone calls, voicemail, email, faxes, videoconferencing, and text messaging. We all use some or all of these on a daily basis. In fact, I would not be able to run my practice without being able to communication with you and other parties, including your medical providers, insurance adjuster, etc. This necessitates use of your protected health information (PHI) such as your name, date of birth, insurance claim number, phone number, email address, etc. Your PHI is also essential for providing psychological services, which typically entails: scheduling and texting appointment reminders; providing you with articles, relaxation exercises, etc. via email; obtaining payment from insurance carriers; and performing other healthcare operations (i.e., submitting requests for prior authorization). As Workers' Compensation insurance carriers are not considered covered entities under HIPAA, claims adjusters, nurse/medical case managers, third party administrators, and attorneys typically do not utilize encrypted email services. The email services used by most patients (i.e., Gmail, Yahoo, etc.) aren't usually encrypted either. While I make a concerted effort to utilize state-of-the-art software, encryption methods, firewalls, and back-up systems in an effort to secure any information stored, submitted, or received by my office and contractors (such as my billing company), there is nevertheless a risk that electronic communications may be compromised, unsecured, and/or accessed by an unintended third-party. That said, even a letter sent through the USPS could potentially breach your PHI if accidentally placed in the wrong mailbox, or is accidentally opened by someone else at your home. I am therefore requesting your written consent for communication of your PHI by unsecured transmissions.

Please note: for completion of intake paperwork and emails that include PHI, I use Hushmail, which is encrypted in both directions. I use Google Meet for telehealth, which is an encrypted and HIPAA-compliant teleconferencing platform. Because texting and my regular email are not encrypted, I ask that they are used for administrative matters only, such as for making and changing appointments, or asking/answering a quick question. Please contact me by phone/voicemail for clinical matters in between sessions rather than sending personal information by text or email (the latter of which I do not check as often). Also, please be sure to review the section, "Contacting Dr. Hawkins" in the Mandatory Disclosure, which discusses what to do in the event of an urgent or potentially life-threatening situation.

By signing this form, I, _____authorize Rebecca Hawkins, Ph.D., PC (DBA Behavioral Medicine Center) to utilize my PHI via unsecured transmissions to communicate with me and the person(s) and/or agency(s) listed on my Authorization for Release of Information. This will also extend to other parties not listed therein for the purpose of fulfilling records requests, provided such is accompanied by a valid, HIPAA-compliant release. I also give my explicit consent to be reached via text and email using the phone number and email address I have listed on my Patient Information form, and release Dr. Hawkins from any and all liability that may occur due to electronic communication over a non-secured network.

_____ _____

Signature of Patient Date

1776 South Jackson Street, Suite 901-5, Denver, CO 80210-3808

behavioral medicine center

new patient questionnaire

Please take a few minutes to complete this form so we can get to know you better.

What is your understanding of why you have been referred to my office? _____

_____

CURRENT PROBLEMS: Please list the problems/complaints you are currently experiencing. Which *one* bothers you the most? (#____)

1.)_____

2.)_____

3.)_____

4.)_____

5.)_____

6.)_____

TREATMENT HISTORY: Please check (✓) each treatment modality/intervention you have had for your *current* injury and/or medical conditions.

✓	Treatment Modality	Provider	Dates or # of Visits	Was this helpful?
	Physical Therapy			☐ Yes ☐ No ☐ Not Sure
	Pool Therapy			☐ Yes ☐ No ☐ Not Sure
	Occupational Therapy			☐ Yes ☐ No ☐ Not Sure
	Massage Therapy			☐ Yes ☐ No ☐ Not Sure
	Acupuncture			☐ Yes ☐ No ☐ Not Sure
	Osteopathic Manipulation			☐ Yes ☐ No ☐ Not Sure
	Chiropractic Manipulation			☐ Yes ☐ No ☐ Not Sure
	Dry Needling			☐ Yes ☐ No ☐ Not Sure
	TENS or Interferential Unit			☐ Yes ☐ No ☐ Not Sure
	Trigger Point Injections			☐ Yes ☐ No ☐ Not Sure
	Occipital Nerve Blocks			☐ Yes ☐ No ☐ Not Sure
	Joint or Local Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Epidural Steroid Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Facet or SI Injection(s)			☐ Yes ☐ No ☐ Not Sure
	Selective/Sympathetic Nerve Block(s)			☐ Yes ☐ No ☐ Not Sure
	Surgery(s)			☐ Yes ☐ No ☐ Not Sure

Turn over, please! ➔

	Other Procedure(s)			☐ Yes ☐ No ☐ Not Sure
	Speech/Cognitive Therapy			☐ Yes ☐ No ☐ Not Sure
	Vestibular or Vision Therapy			☐ Yes ☐ No ☐ Not Sure
	Psychotherapy/Counseling			☐ Yes ☐ No ☐ Not Sure
	Biofeedback			☐ Yes ☐ No ☐ Not Sure
	Psychological Evaluation			☐ Yes ☐ No ☐ Not Sure
	Psychiatric Evaluation			☐ Yes ☐ No ☐ Not Sure
	Independent Medical Eval(s)			☐ Yes ☐ No ☐ Not Sure

What providers are you *currently* seeing?_____

Are you satisfied with your providers and current medical care? ☐ Yes ☐ No; please explain:_____

_____

Are you currently performing a home exercise program? ☐ No ☐ Yes; how often?_____

Any upcoming surgeries, procedures, or new referrals pending?_____

What are your goals for treatment?_____

CURRENT MEDICATIONS: Please list ***all*** medications (prescription and **over-the-counter**) you are taking.

Medication Name	Dose (mg)	Time(s)/Day	Prescribing Physician	Is this medication helpful?
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure
				☐ Yes ☐ No ☐ Not Sure

Are you *currently* taking any vitamins, homeopathic, or herbal supplements? ☐ No ☐ Yes; please list:

_____

Any allergies to medications, latex, or adhesives? ☐ No ☐ Yes; please list: _____

MEDICAL HISTORY: Any prior surgeries, medical conditions/illnesses, or hospitalizations not listed above?__

_____

_____

Please circle/list any significant **family** medical history (i.e., high blood pressure, diabetes, cancer, stroke, heart disease, neurological problems, autoimmune disorders, thyroid disease, etc.): _____

_____

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Welcome to the Behavioral Medicine Center (BMC). This document, known as the "Mandatory Disclosure" is required by law by the State of Colorado. It also contains important information about our policies and your rights as a client/patient, including confidentiality. The Health Insurance Portability and is Accountability Act (HIPAA) is a federal law that provides additional privacy protections with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is posted at our office and online at http://behavioralmedicinectr.com/noticeofpp.pdf, explains HIPAA and its application to your personal health information in greater detail. Because the BMC is compliant with HIPAA, we are required to obtain your signature to acknowledge that we have provided you with this information. However, it is duly noted that Workers' Compensation (WC) insurance carriers are not covered entities under HIPAA.

INFORMATION ABOUT DR. HAWKINS

Dr. Hawkins received her Ph.D. in Clinical Psychology from the Graduate School of Psychology at Fuller Theological Seminary in September of 2000. She also holds a M.A. in Psychology from the same school and a Master's degree in Christian Leadership (Integrative Studies) from the Graduate School of Theology at Fuller Theological Seminary. Dr. Hawkins is a Board Certified Clinical Health Psychologist and Licensed Clinical Psychologist (CO #2582). A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and 40 hours of continuing education every two years. Requirements to become Board Certified in Clinical Health Psychology by the American Board of Professional Psychology (ABPP) include: a doctoral degree from an accredited program in professional psychology; at least two endorsements by appropriately qualified professionals; an appropriately credentialed one-year full-time internship program; one-year postdoctoral supervised experience in professional psychology, two additional years of post-doctoral experience in clinical health psychology; and licensure as a psychologist. Additionally, practice samples were reviewed by the specialty board along with an oral examination.

Dr. Hawkins is Board Certified in Biofeedback by the Biofeedback Certification International Alliance (BCIA, #B4445), which requires 30 hours of continuing education every four years for Senior Fellows. Initial certification required: at least a bachelor's degree in an approved field from a regionally-accredited university; 48 hours of BCIA-approved didactic education; coursework in human anatomy/physiology or biology; 20 contact hours with a BCIA-approved mentor to review 10 sessions of personal biofeedback, 50 sessions of client treatment, and 10 hours of case conference presentations; passing the BCIA written examination; and holding a health care license in a BCIA-approved health care field or supervision by an appropriately-credentialed health care professional. Dr. Hawkins also received a Certificate of Completion in Eye Movement Desensitization and Reprocessing (EMDR) Basic Training from an approved training provider of the EMDR International Association after completing 40 hours of didactic education and 10 hours of group consultation.

INFORMATION ON CO REGULATIONS FOR MENTAL HEALTH PROFESSIONALS

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 Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary degree(s) and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is simply registered with the State Board of Registered Psychotherapists, but is not licensed, certified, or required to have advanced degrees, specific training, or experience in counseling or psychology.

PATIENT RIGHTS

- You are entitled to receive information from Dr. Hawkins about her methods of therapy, the techniques she uses, the duration of your therapy (if known), and fees for her services.
- You can seek a second opinion from another psychologist/therapist or terminate treatment 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.
- **Confidentiality:** Generally speaking, the information provided by and to a patient during therapy sessions is legally confidential and cannot be released without your consent. There are exceptions however, some of which are listed in section 12-43-218 of the Colorado Mental Health Statute and other laws of medical confidentiality in the State of Colorado. Pertaining to WC cases specifically, I am required to provide information to your referring physician and WC insurance carrier. Other exceptions that may merit departure from the standard confidentiality rules that you should be aware of include: situations that raise suspicion of abuse, neglect, or exploitation of children or an "at-risk" adult/elder; and serious threats to the health or safety of yourself or someone else. Additional exceptions to this rule for the purpose of billing and conducting healthcare operations are also discussed in the Notice. Of note, I am required by Colorado Law to maintain your records for seven years following termination of services or our last contact. However, I cannot guarantee that they will exist thereafter.

PATIENT RESPONSIBILITIES & OFFICE POLICIES

- Payment for services, including co-payments and/or deductible (if using insurance), is expected at the time of service unless prior arrangements or pre-authorization have been made through your insurance company. Please note that we accept payment by cash, check, or credit card.
- **Cancellation Policy:** If you are unable to attend a psychotherapy or biofeedback session, you are required to provide notice of cancellation *at least 24 hours in advance* by calling **(303) 830-1181**. Unless the result of a bona fide emergency, we reserve the right to bill you for the cost of the missed session/late cancellation. In most cases, this fee will not be covered by your insurance company and must be paid directly by you. For cancellation of any Psychological or Neuropsychological Evaluation we request *three business days' notice*. We also reserve the right to charge you a $150 cancellation fee for all evaluations, if not cancelled in accordance with this policy.
- **Discharge Policy:** It is your responsibility to make and keep your appointments for your recommended course of treatment. If you miss *three visits* (including late cancellations [with <24 hours' notice] and/or no-shows), or if you simply do not return for follow-up within one month (unless by mutual agreement), Dr. Hawkins may opt to discontinue your course of treatment for noncompliance. We will also notify your referring/treating provider(s) and insurance carrier of your discharge from the practice.
- Please note that you are financially responsible for any and all services provided on your behalf that are not paid by your insurance. While every effort will be made to accommodate your particular insurance plan, we cannot guarantee that your insurance carrier will cover all costs of treatment. Again, whatever is not covered by your insurance will be your responsibility. We reserve the option of using legal means or a collection agency to secure payment of account balances past due. The only exception to this is that we agree to accept payment by a motor vehicle accident or Workers' Compensation carrier as full and final payment, if such carrier agrees to pay for this care or if we are contracted to accept reduced rates with your particular carrier.
- **Contacting Dr. Hawkins:** To schedule an appointment with or to reach Dr. Hawkins, please call (303) 830-1181. While Dr. Hawkins strives to return patient calls within a timely manner, she may not always be immediately available. In the case of a non-life-threatening situation that requires urgent attention outside of normal business hours (Mon-Thurs, 8 am–6 pm) Dr. Hawkins can be reached on her cell at (720) 394-4385. However, if you feel you are in a potentially life-threatening situation (e.g., having thoughts about harming yourself or someone else), please do not wait for a returned call, but instead go to the nearest emergency room or call 911. Alternatively, you may also call Highlands Behavioral Health at (720) 348-2800 for a mental health assessment, as they have staff available 24 hours a day, seven days per week. If Dr. Hawkins will be unavailable by phone for an extended time, the name and phone number of a colleague to contact in her absence will be left on the outgoing message at (303) 830-1181.

If you have any questions about this information or the services provided at the BMC, please feel free to ask.

YOUR SIGNATURE BELOW SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE READ THE PRECEEDING INFORMATION (THAT WILL ALSO BE PROVIDED VERBALLY AT YOUR FIRST VISIT) AND UNDERSTAND YOUR RIGHTS AS A PATIENT. YOUR SIGNATURE ALSO SERVES AS: ACKNOWLEDGEMENT OF THE HIPAA NOTICE; CONSENT FOR EVALUATION AND/OR TREATMENT; AND AGREEMENT WITH THE ABOVE TERMS.

Patient Signature_____ Date_____

Provider Signature_____ Date_____

[Please note: a copy of this form was sent to you via email for future reference.]