SPECTRA LLC

Lisa Drey, RN MA CNS CACIII PMHNP LPC RXN

**28677 Buffalo Park Rd.**

**Suite # 204**

**Evergreen, CO 80439**

**P: 720 326 2930**

**F: 800 928 0250**

Welcome to my practice. I look forward to working with you.

I work with adult men and women to provide psychiatric, chemical dependency, and psychotropic medication evaluations, recommendations, psychotherapy, and medication management. In rare situations, I may provide psychotherapy alone. Most often however, I provide psychotherapy as an addition to medication management. If you are already working with a therapist, I will consult with your therapist and your physicians as allowed, in order to provide continuity of care.

**COMMUNICATIONS:**

My practice is part time and therefore I have some limited availability. The most efficient way for us to communicate regarding non-urgent matters is by email. When the matter is time sensitive or urgent, a phone call AND an email is best. PLEASE DO NOT TEXT ME AS THERE IS NO WAY FOR ME TO KNOW WHO IS TEXTING AND DOCUMENTING TEXTS IN CHARTS IS PROBLEMATIC.

For emergencies, you should contact 911 or go to your nearest emergency room. Please do not contact me by email for any urgent or emergent issues, as there will likely be a delay in getting help. If you are someone who tends to have frequent urgent or emergent crises or who requires frequent phone contact, I may need to refer you to another health care provider who would have more resources available.

I do not have billing services, receptionists, secretaries, nurses, or clerical help and I am not in the office every day. Please keep this in mind when making requests.

**MEDICATION REFILLS:**

For that reason also, I make every attempt to provide refills during sessions. There should be only very rare occasions where there is a need for me to call in a prescription. ALL REFILLS ARE TO BE MADE DURING SESSIONS AND SCHEDULING IS ARRANGED TO ACCOMADATE THAT PROCESS. Please be sure to check with the pharmacy before contacting me for a refill to first make sure that there aren’t already refills available to you, and PLEASE have your pharmacy contact me to request the refills. This is the most efficient way to accomplish timely requests. I provide a 90- day supply of medicine only when you are stable on the current dose of the current medication.

DUE TO THE RECENT INCREASE IN THE NUMBER OF PRIOR AUTHORIZATIONS THAT IINSURANCE COMPANIES ARE REQUIRING, THERE WILL BE A CHARGE TO THE PATIENT FOR PRIOR AUTHORIZATION REVIEWS. PLEASE SEE FEE SCHEDULE

**REFERRING OUT TO ANOTHER PROVIDER:**

There are some circumstances where I will make the determination that your situation is better provided by a physician (psychiatrist). Usually these are situations where a person’s case is complicated either by multiple medical problems, multiple medication requirements, or circumstances that present a threat to safety. Once this determination is made, I can no longer provide treatment but will assist you in finding a psychiatrist who can take over your care.

**ASSESSMENT, EVALUATION, AND TREATMENT:**

I will have you fill out several forms to assist in the evaluation your medical status, mood status, and history. These forms may not address all of your concerns and we may go over them during sessions allowing for more detail. I will take into account your own goals for treatment as we determine your treatment plan.

The first visit usually lasts between and hour and an hour and two hours following completion of your paperwork. The follow up visits may last anywhere between 15 minutes to 45 minutes. A fee schedule can be found on the last page of the new patient packet. The length and frequency of your visits will be determined by your individual needs and may require additional payment for time spent going beyond the above time frames. Please let me know of any issues concerning ability to pay at the very start of the session so that we can address them before going any further. I do not compromise my standards of care for any reason. The inability to pay for services does not change the kind of services that a patient needs. Therefore, if this situation presents itself, I will refer you to an appropriate treatment setting.

On each follow up, I will assess your progress, side effects, changes in your health and medications, need for labs, and develop a plan for continued treatment. I may suggest further treatment or homework assignments as well as medication changes. We will then schedule a follow up visit. At some point, if it is appropriate, we will make a plan to take you off of your medications.

Initially, I may need to see you several times per month to evaluate your progress. Eventually I may need to see you as infrequently as once every three months. That is the minimum requirement for safe practice when managing psychotropic medications and is the minimal acceptable standard of care in the community. However the frequency of visits is always determined by your condition.

**CONFIDENTIALITY:**

I will treat with great care all the information you share with me. It is your legal right that our sessions and my records about you are kept private. That is why I ask you to sign a “release of records” form before I can talk about you or send my records about you to anyone else. However, there are some legal limits to your confidentiality. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person. This usually means telling others about the threat. I cannot promise never to tell others about threats you make. If I have a reasonable suspicion that a child has been or will be abused or neglected, I am legally required to report this to the authorities. If I have knowledge that you are harming a vulnerable person under your care, such as an elder or disabled person, I have a legal and ethical obligation to intervene protectively. Other instances when I may have to divulge confidential information without your authorization involve court orders compelling

The information you discuss during a psychotherapy session is protected as confidential under law (CRS 12,43,214 (l)(d)) with certain limitations.

•It is my policy to report suspected child abuse without an investigation to the proper authorities whom may then investigate.

•I also may take some action, such as seek an order for your emergency or involuntary commitment, without your consent if I deem you to be a serious harm to yourself or another. Any action I take without your consent will be discussed with you.

•If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency.

•If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.

•If you choose to use your health benefit plan, you will have given your insurance or managed care company consent to obtain required confidential information for the purpose of determining eligibility for reimbursement.

•I may seek consultation from another mental health professional. However. Your identity will not be revealed without your consent, and that professional will also protect your privacy.

•Clerical persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative purposes.

•When I am away from my office for a few days, I may ask another licensed therapist to cover emergencies for me. Generally, I will tell this therapist only what he or she needs to know for an emergency.

PLEASE BE AWARE THAT ALTHOUGH OUR COMMUNICATION WHETHER BY PHONE, EMAIL, VOICE MAIL, OR FAX IS CONFIDENTIAL, IT IS NOT ENCRYPTED.

**FEE PAYMENT:**

Fees are payable at the time of service and are paid directly to me. I can accept cash and credit cards. Unfortunately, due to problems with returned checks, I have had to modify some of my business practices.

**IF THERE IS SOME REASON (such as my credit card reader malfunctioning) THAT I WOULD ACCEPT A CHECK: THERE WILL BE A FEE CHARGED TO YOUR ACCOUNT OF $45.00 FOR ALL RETURNED CHECKS. IF FOR SOME REASON YOUR FEE IS NOT PAID AT THE TIME OF THE VISIT, A LATE FEE OF $10.00 MAY BE ADDED EACH MONTH UNTIL THE BALANCE IS PAID.**

After the return of a check, I will only accept cash. In the event that your account becomes delinquent and is turned over for collections, you will be responsible for all late fees, collection fees, court costs and attorney fees should legal action be taken in accordance with collections as well as interest on the account balance. **If you do not have payment with you, and I have not received payment by end of the billing cycle, I will send you a statement however there will be an additional billing fee of $10.00.**

**In your preliminary paper work you will find a form called “permission to charge credit card”. All patients must complete and sign this form prior to receiving treatment. The card is to be kept on file for any unpaid balance. These cards must specifically be credit cards as opposed to debit cards, H.S.A. cards, or any other type of card.**

**HEALTH CARE BENEFITS/INSURANCE:**

Currently, I do not contract with any insurance companiesIt’s expected that the client will pay the full amount of the fee to the provider at the time of service. I can provide a form for you to send to your insurance company to collect reimbursement from them. All services provided are the financial responsibility of you, the client.

**AVAILABILITY:**

There is no charge for brief calls of a business nature. However, calls lasting longer than ten minutes will be charged at the session rate on a prorated basis. **Your insurance company may not reimburse for this service.** You would be responsible for direct payment. (See fee schedule on last page).

You may leave a voice mail message 24 hours a day, and I or a designated backup clinician will make every attempt to return your call within 24 hours during the weekdays or on the first working day following a weekend or holiday. While I am usually able to cover my own after-hours calls, I will designate a backup clinician to cover any urgent calls during vacations or times when I cannot receive calls. **There may be a charge for after hour calls at an additional fee. In an emergency situation, you are instructed to call 911 or go to your nearest emergency room.**

**CONTROLLED SUBSTANCES:**

I have some very specific policies and procedures when it comes to prescribing controlled substances. I can go over those with you in the office. The most important one to be aware of is that I do not replace lost, stolen, or otherwise missing prescriptions. You are out of luck if you misplace your prescription. If the situation of running out of medicine presents a medical emergency, you will be prescribed other n on-controlled substances to maintain your safety. I monitor patient medication use via the Colorado Prescription Drug Monitoring Program, which provides information to prescribers such as time of last refill, and names of additional prescribing clinicians.

**CANCELLATIONS:**

It is my policy to charge my **full fee** for cancellations received less than 24 hours (including weekends) prior to a scheduled appointment. In other words, if your appointment is on a Monday at 2:00 pm, the appointment must be cancelled no later than Friday at 2:00 PM in order to avoid being charged. If 24 hours cannot be given, every attempt will be made to fill your appointment, and a charge will not be made if this can be done. It is important to remember that **insurance companies do not pay for missed appointments.**

**REPORTS:**

Occasionally requests are received from various agencies for written reports related to psychotherapy. These requests can only be filled if the client signs a Release of Information form. Unless very brief, a charge based on the use of the provider’s time will be made for this service. Your insurance company may not reimburse you for this service. You would be responsible for direct payment.

**TERMINATION:**

Termination will usually be agreed upon mutually, but you are free to terminate at any time. However, in a few special instances I may decide to stop working with you even though you wish to continue. These include a failure to meet the terms of our fee agreement, a need for special services outside of the area of my competency, frequently missed appointments, non-compliance with your treatment plan, inappropriate use of after hour services, and prolonged failure to make progress in our work together. Should this occur, the reason for termination will be discussed with you, and you will be helped to make different plans for yourself, including a referral to more appropriate resources.

**Your Rights As A Patient:**

• **Additional Restrictions:** You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form.

• **Alternative Means of Receiving Confidential Communications:** You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

• **Access to Protected Health Information:** You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist and are treated differently. IF it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form and the appeal process.

• **Amendment of Your Record:** You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the practice will ensure that the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form and the appeal process available to you.

**Accounting of Disclosures:** You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment or health care operations or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

• **Right to Revoke Consent or Authorization:** You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

• **Copy of this Notice: You have a right to obtain a copy of this notice upon request.**

The practice is required to abide by the terms of this notice, or any amended notice that may follow. The Practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. When changes are made, the revised notice will be posted at the Practitioner’s office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

**DISCLOSURE STATEMENT**

The practice of both licensed and unlicensed psychotherapists is regulated by the Department of Regulatory Agencies under CRS 12.43.214 (1)(c). Questions or complaints may be addressed to:

CO State Grievance Board

1560 Broadway, Suite 1340

Denver, CO 80202

(303) 894-7760

Under this statute, 12.43.214 (1)(d) CRS, you are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship sexual intimacy is inappropriate and should be reported to the Grievance Board.

12.43.214 (1)(d) CRS states that information provided by a client during therapy sessions is legally confidential except as provided in section 12.43.218 and except for certain legal exceptions which will be identified by the licensee should any such situation arise during therapy.

**DEGREES AND CREDENTIALS**

Certified as Psychiatric Clinical Nurse Specialist; Certified Psychiatric Mental Health Nurse Practitioner, Prescriptive Privileges: Registered Nurse; Bachelor of Science in Human Services; Masters of Arts in Agency Counseling; Level III Certification, Alcohol Drug Abuse Division Colorado Department of Health. Extensive specialized training in group psychotherapy, psychodrama, case management, and utilization management and managed care contracting.

COMPLETION OF EDUCATION AND OTHER TRAINING

**Jan 2002**: American Nurses Credentialing Center – Washington D.C.

Certified Adult Psychiatric Mental Health Nurse Practitioner

**July 2000**: Prescriptive Privileges Granted

Collaborative agreement with Dr. Stephen Popkin

**May 1996**: Advanced Practice Registry/Colorado Board of Nursing. Cert. #1882file://localhost/message/%253C4ED6F3E5.3050507@cox.net%253E

**October 1990**: American Nurses Credentialing Center – Washington D.C.

Certification as Clinical Nurse Specialist in Adult Psychiatric and Mental Health Nursing.

**June 1988:** University of Northern Colorado - Greeley, CO.

Master of Arts in Agency Counseling

**October 1987:** Colorado Psychodrama Center – Lakewood, CO

Completed 400-hour internship.

**August 1985:** Metropolitan State College – Denver, CO

Bachelor of Science in Human Services, Emphasis on Drugs, Alcohol and Addictive Behavior.

**July 1984:** Colorado Department of Health, Alcohol Drug Abuse Division – Denver, CO

Certification Alcohol Drug Abuse Counselor

**February 1981**: Evanston Hospital, Northwestern University – Evanston, IL

Registered Nurse Diploma

**I have been informed of my therapist's degrees, credentials, and licenses. I have also read the preceding information and understand my rights and responsibilities as a client. I authorize my consent to treatment.**

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Clients Signature

Date

**I have read and understand the fee schedule and I agree to pay for services rendered accordingly.**

**I understand that I am responsible for fees incurred and that if my account becomes delinquent, it may be turned over to collections. I understand that I am responsible for any legal fees incurred due to the collections process.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Signature

Date