Merk
Child & Family
Behavioral Health

421 Highway 6 & 50
Fruita, CO 81521
Phone: 702-573-5916
www.merkbehavioralhealth.com

Welcome to Merk Child and Family Behavioral Health, LLC

Thank you for choosing Dr. Merk to assist you and your family. Please complete the attached forms as soon as possible before your first appointment. If you have any questions or need assistance with completing any of the forms, please contact Dr. Merk at drmerk@merkbehavioralhealth.com or 702-573-5916. Forms should be returned to drmerk@merkbehavioralhealth.com.

Registration Form and Requested Information for Care

Last Name: First Name:

Date of Birth:

Ethnicity:

Gender:

Address:

Appointment Reminder and Contact Number:

Can a confidential voicemail be left at this number? Yes No

Who can we thank for the referral?

In case of emergency who should we notify?

Primary Care Physician:

Responsible Party (Legal Guardian):

First Name: Last Name:

Address:

Date of Birth:

Phone Number:

Email Address:

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Relationship to Client:

Spouse/Other Parent:

First Name: Last Name:

Address:

Date of Birth:

Phone Number:

Email Address:

Relationship to Client:

Demographic Questionnaire and Presenting Concerns:

Form Completed by:

Primary Reason(s) for Seeking Services:

Divorced/Separated/Not Living Together:

If yes, please note who resides in each household:

Household 1:

Name Age Relationship

Name Age Relationship

Name Age Relationship

Name Age Relationship

Name Age Relationship

Household 2:

Name Age Relationship

Name Age Relationship

Name Age Relationship

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Name Age Relationship

Educational History

Current School and Grade:

Does your child currently have special education supports? Yes No

If so, please email a copy of the report/services provided.

Has your child received previous mental health care? If so, please list the date of services and the provider.

Mo/Yr Provider

Mo/Yr Provider

Developmental history:

Complications at birth or in early childhood? If yes, please explain:

Medical diagnoses and conditions: If yes, please explain:

Significant operations/invasive procedures: If yes, please explain:

Serious injuries/chronic illnesses/hospitalizations: If yes, please explain

Last Visit to Doctor/Pediatrician and Name of Provider:

Allergies:

Medications:

Medication Dosage Prescribing Physician Started

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Medication Dosage Prescribing Physician Started

Current Legal Concerns, If yes, explain:

Current Concerns Related to Substance Abuse, If yes, explain:

Parent/Client Signature: Date

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Treatment Services Agreement and Consent Form

Welcome to Merk Child and Family Behavioral Health (MCFBH). This document contains important information about our professional services and business practices. Please read this document carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and MCFBH.

Services Offered

MCFBH is dedicated to creating and maintaining a collaborative approach with the client and their families, focusing on evidence based and scientifically validated treatment services. MCFBH understands every client is unique with differing circumstances. Given this, we work with you and your family to identify goals consistent with your needs. Parent/caregivers participation is an expectation of service. Participation may include discussion of family needs, psychoeducational information, implementation of recommended strategies, and discussion of scheduling. MCFBH provides a range of services including mental health services, including intake evaluations and individual and family therapy for an array of presenting problems and mental health disorders. MCFBH also provides psychoeducational and training services.

Appointments

Any party may cancel or reschedule sessions previously scheduled. MCFBH understands there are circumstances that arise, such as illness or family emergencies, which necessitate the cancellation of appointments. All appointments require a 24-hour cancellation notice to avoid being charged. **Please note the charge for an appointment canceled without 24-hour notice or if a client does not show to an appointment, a $150.00 fee will be charged**. Cancellations must be made by phone, text, or email. Excessive cancellations (defined as 3 or more) may result in termination of services, as consistency is critical for treatment success. **Tardiness: If you are 15 minutes or more late, the appointment will be rescheduled.**

Communication

Dr. Merk is committed to providing quality services, which include timely and professional communication. If you have basic questions about MCFBH you are welcome to send an email to drmerk@merkbehavioralhealth.com. MCFBH **does not provide on-call coverage 24 hours per day, 7 days per week**. In the event of an emergency, please contact your physician or call 911 and/or go to the nearest hospital emergency room. Clients may contact Dr. Merk with non-emergency-related questions or comments by telephone or email. Office hours are generally 8am-5pm MDT Monday-Friday unless otherwise indicated. Please allow for 1-2 business days for email responses.

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Privacy Practice: Confidentiality, Records, and Release of Information

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where, and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep records of your symptoms, examinations, test results, diagnosis, treatment plans, progress notes, and other medical information. We also may obtain health records from other providers.

MCFBH is required to adhere to the Federal Health Insurance Portability and Accountability Act (HIPAA), when using and disclosing Protected Health Information (PHI). In using and disclosing this PHI we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA), 45CFR, Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations, and other specified purposes as outlined in this document. This includes contacting you for appointment reminders and follow-up care.

If you request information to be shared with other treatment providers, you will first need to sign a written Authorization to Release Protected Health Information specifying what information can be released and to whom it can be shared. There are times when state laws may require the disclosure of confidential information without expressed written permission under certain circumstances. These circumstances include: if a person is in danger of hurting themselves or someone else; child abuse, elder abuse, or abuse of a vulnerable adult is suspected; or if court ordered. Dr. Merk is a mandatory reporter. As such, if we have reasonable cause to suspect that a minor child, disabled person regardless of age, or an elderly adult has been the victim of, or will be the victim of, physical or sexual abuse, neglect, exploitation, abandonment, or other forms of maltreatment, Dr. Merk is legally mandated to report to the appropriate authorities.

MCFBH staff routinely consult with other professionals. In doing so, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them.

Disclosures Requiring Authorization: All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent that we have already relied upon the authorization.

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Record Retention

For a client residing in Nevada: Per NRS 629.051, Section 7, psychologists are required to maintain records for adult clients over 23 years of age, for five years. Children's records will be maintained until 23 years of age. After that time, records may be destroyed.

For a client residing in Colorado: Per C.R.S. sections 12-245-204, every psychologist shall create and maintain records on each of their psychology clients. The psychologist shall retain a record on each psychology client for a period of seven years commencing on the date of termination of psychology services or on the date of last date of treatment with the client, whichever is later. When the client is a child, the record shall be retained for a period of seven years commencing either upon the last date of treatment or when the child reaches eighteen years of age, whichever is later.

Client Rights and Responsibilities

You have the right to:

- Request a restriction of the uses and disclosures of Private Health Information (PHI) as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to Dr. Merk. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of $.60 per page and the actual cost of postage per NRS 629.061, except that you are not entitled to access to, or to obtain a copy of psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to Dr. Merk. In most cases, we will respond within 30 days. We are not required to agree to the request amendment.
- Obtain an accounting of disclosures of your PHI, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorizations, among other exceptions.
- Request in writing to Dr. Merk that we communicate with you by a specific method and at a specific location. We will typically communicate with you by letter, email, fax, and/or telephone.
- Revoke authorization to use or disclose PHI at any time except when action has already taken place.

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- Participate actively in decisions regarding your child's care and to receive as much information as you may need in order to give informed consent
- Receive reasonable continuity of care and know in advance the time of your appointments as well as the identity of the person providing the care.
- Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, or marital status or the source of payment for care.

Our Responsibilities: The law requires us to:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practice with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practice and we will apply the change to all of your protected health information, including information obtained prior to the change.
- Provide you with the Privacy Policy upon request.
- Use or disclose your health information only with your authorization except as described in this document.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your health information.

For More Information or to Report a Problem:

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. The Practice will not retaliate against you for filing a complaint.

Legal/Custody Evaluations

• MCFBH does not provide any services or evaluations pertaining to litigation, forensic evaluations, and/or custody evaluations.
• All legal guardians must agree to not ask MCFBH to testify in court in any way, shape, or form. We will not provide evaluation results to the court or attorneys for litigation or other purposes. All legal guardians must agree to instruct their attorneys to not subpoena or refer to clinicians or staff of MCFBH in any way, shape, or form in any court filing. If we are required to testify or release records under court order, we retain the right to terminate psychological services.

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• Staff at MCFBH are ethically bound to not provide opinion regarding either parent's/guardian's fitness for custody or visitation.

• If clinicians and/or staff of MCFBH are required to participate in court or legal proceedings of any type, the party responsible for the participation agrees to reimburse MCFBH at the rate of $1,650.00 for a half-day (up to 4 hours) and $3,000 for a full-day (up to 8 hours) for time spent traveling, preparing reports, testifying, being in attendance, and any and all other case-related activities or costs.

Fees	
The following fee schedule represents the fee-for-service rates as of 10/7/2025:	
Intake Evaluation (60-90 minutes):	$350.00
Individual Therapy (30 minutes):	$200.00
Individual Therapy (45–50 minutes):	$225.00
Individual Therapy (60 minutes):	$250.00
Family Therapy (45–50 minutes):	$250.00

Miscellaneous Fees (letter writing, FMLA paperwork, consultation with other professionals, attendance at meetings (IEPs), review and providing feedback for documents, and related tasks): $50/15 minutes with 15 minute minimum.

Please inquire with Dr. Merk should you require information on fees for specific services not listed above. Payment for all treatment services is due at the time of the service, unless other arrangements have been made. If your insurance carrier provides financial assistance for treatment services, and MCFBH is a contracted provider for your insurance, MCFBH will discuss the procedures for billing your insurance carrier. The amount of reimbursement and the amount of any co-payment or deductible depends on the requirements of your specific insurance plan. You should also be aware you are responsible for verifying and understanding the limits of your insurance coverage. You understand you are financially responsible for all charges whether paid by your insurance. Payment is collected through our online patient portal where your credit card information will be collected and on file for services. No other forms of payment will be accepted. The card will not be charged unless there is a default in payment, which includes a missed appointment or balance due. Failure to pay your account within 90 days will result in your account likely being referred to a collection agency. Expenses incurred by the collection agency will be your responsibility. Cash-pay patients can be provided with a "Record of Services Provided and Fees Collected" to submit to their insurance company for possible reimbursement (if the patient is eligible for out-of-network benefits) upon request. Our office does not provide refunds for appointments cancelled by patients or that patients failed to attend**.** If you close the account used as payment you must notify Dr. Merk and provide another form of payment.

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You understand you are financially responsible for all charges. In the event your account becomes past due, your balance will accrue interest at the rate of 1% per month (i.e. 12% per annum). If you fail to pay in full or make any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill, (or we are unable to locate/notify you of your account status despite reasonable effort) your balance will be turned over to an outside office Collection Agency. A $50 charge will be assessed to all collection accounts, in addition to any accrued interest. If your account is referred to a Collection Agency, interest will continue to accrue at the rate noted herein. In addition, you will be responsible for all added percentage-based Collection fees/costs per our prevailing collection company contract, Attorney fees, Court Costs, Administrative/Service Fees & associated Miscellaneous Fees and Costs. You authorize said assignee to release all necessary information to secure the payment of said benefits.

Informed Consent for Services

Your signature below indicates you have received and read the information in this document. Consent by all parents/legal guardians is required prior to treatment services being provided to minor children. These policies have been explained, and I fully and freely give my consent for services to be provided.

Client's Name Date

Client/Parent/Legal Guardian Signature Date

MCFBH Representative Date

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Consent to Use Electronic Communication

Risks to confidentiality and privacy. We offer helpful administrative information via text messaging, emails, phone and conduct video appointments. There is some level of risk, that information in a regular text message or email could be read by someone besides you. The treatment providers cannot ensure the confidentiality of any form of communication through electronic media or guarantee absolute protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically.

Please indicate below your communication preferences.

☐ YES–please communicate with me by email. My email address is:

☐ NO – please do not communicate with me by email

☐ YES – please communicate with me by text message. My cell phone number is:

☐ NO – please do not communicate with me by text message

☐ YES – I give permission for voicemail messages to be left on the phone number on file.

☐ NO – please do not leave voicemail messages.

I am aware of the risks associated with digital communication and allow Merk Child and Family Behavioral Health to contact me as indicated above. It is my responsibility to alert Merk Child and Family Behavioral Health in writing of any changes to my contact information or if I want to opt-out of these options.

Client's Name

Date

Parent/Legal Guardian Signature

Date

Merk Child and Family Behavioral Health Services Representative

Date

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Legal Guardianship

Patient Name:

Patient Date of Birth:

I, the undersigned, indicate by my signature below that I have legal custody/legal guardianship of my child (named above), and, therefore, the right to seek evaluation and/ or treatment for my child. I have been advised by Merk Child and Family Behavioral Health that it is their recommendation that my child's other parent, if any, be informed of my decision to seek evaluation and/or treatment.

Printed Name - Parent or Legal Guardian Date

Signature Date

Merk Child and Family Behavioral Health Services Representative Date

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Mandatory Disclosure Statement for Rachele Merk, PhD

My academic degrees include a PhD, a Doctorate, in Clinical Psychology from the University of Nevada Las Vegas. I am licensed as a Psychologist in the state of Nevada since 2018 and in Colorado since 2025. In order to comply with § 12-245-216(1)(b)(I), C.R.S I must inform you about the following professions:

A Registered Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience.
- A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.
- A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.
- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

The practice of licensed and unlicensed persons in the field of psychology, is regulated by the Department of Regulatory Agencies. Questions or complaints should be addressed to: State

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Grievance Board, Department of Regulatory Agencies, 1560 Broadway, Suite 1340, Denver, CO 80202. Their phone number is (303) 894-7800.

In a professional relationship such as ours, sexual intimacy between a therapist and patient is never appropriate and never condoned. If sexual intimacy occurs, it should be reported to the State Grievance Board. You are entitled to receive information about my methods of therapy, the techniques used, the expected duration of therapy (if known), and the fee structure. You may seek a second opinion from another therapist at any time. In general, the information provided by a patient during psychotherapy sessions is legally confidential if the therapist is a licensed psychologist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the patient's consent.

There are certain exceptions to the general rule of legal confidentiality, including: if a patient appears to be a danger to self or others; or when treatment is provided pursuant to criminal or delinquency proceedings. Additionally, in the event of actual or suspected child, vulnerable adult, or elder abuse or neglect, I am required by law to report this to the Department of Social Services and/or Law Enforcement. No information about you will be released to a third party without your written permission.

As a sole provider in independent practice, I am unable to emergency care or intensive services. If you believe that you will need frequent emergency attention between scheduled sessions, please discuss this with me immediately so that I can refer you to a provider who can better serve your needs.

If you have questions or would like additional information, please feel free to ask.

I have read the preceding information and understand my rights as a patient.

Print Client name

Print Parent/Guardian Name

Signature Date

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Telehealth Agreement Consent

1. You understand that "telehealth" includes consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications. You also understand that telehealth also involves the communication of your medical/mental health information, both orally and visually.
2. Unless otherwise discussed, communicate occurring via telehealth is strictly confidential. I will not release your information to anyone without your prior approval unless I am required to do so by law. In Colorado and in Nevada, where I am licensed as a psychologist, we are required to notify authorities if we become convinced a client is about to physically harm someone, or if they are abusing or about to abuse the elderly, children, or the disabled.
3. You understand that you are required to be in the state of your residency at the time of your appointment.
4. You have the right to withdraw or terminate treatment at any time.
5. You understand that some Telehealth platforms allow for video or audio recordings and that neither you nor my therapist may record the sessions without the other party's written permission.
6. You understand that there are risks and consequences with telehealth services including, but not limited to, the possibility, that: the transmission of your medical information could be disrupted by technical failures; and/or the electronic storage of your medical information could be accessed by unauthorized persons.
7. You understand that not all person's benefit from telehealth services and some conditions or needs are better served through face-to-face professional support. If I believe that your needs would best be served by a local professional, referrals will be provided to a professional in your area.
8. You understand that despite our best efforts, results cannot be guaranteed or assured.
9. You understand and acknowledge that we do not provide emergency services. If you are experiencing an emergency situation, you understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If you are having suicidal thoughts or plan to harm yourself, you may also contact (call or text) the Suicide and Crisis Hotline at 988.
10. For our meetings: you are responsible for arranging a private location with sufficient lighting; securing or encrypting protected health information (PHI) transmitted to or stored on your computer/telecommunications device; and providing necessary computer or related equipment and internet access to access your telehealth appointment.
11. You understand that email will be used as a form of communication and confidentiality cannot 100% be guaranteed due to outside factors including viruses or other involuntary intrusions that may obtain and distribute confidential information.

I have read and understand the information provided above and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Print Client Name:

Parent/guardian/other authorized Signature:

Date:

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Authorization to Release/Request Protected Health Information

Client Name: Date of Birth:

☐ I authorize Merk Child and Family Behavioral Health to contact/communicate with my child's Primary Care and/or Medical Provider

☐ I do not authorize Merk Child and Family Behavioral Health to contact/communicate with my child's Primary Care and/or Medical Provider

To/From (of Primary Care Provider/Medical Provider/Clinic)

Name:

Clinic Address:

Phone: Fax:

Email address:

Release Method: (check all that apply): ☐ Email ☐ Mail ☐ Fax ☐ Pickup ☐ Verbal ☐ Other:

By signing this authorization form, I understand that:

• I have the right to revoke this authorization at any time. Revocation must be made in writing to Merk Child and Family Behavioral Health, at the address listed below. Revocation will not apply to information that has already been disclosed in response to this authorization.

• Unless revoked, this authorization will expire in one (1) year from the date signed or on the following date/event whichever occurs sooner.

• Treatment may not be conditioned on whether I sign this authorization.

• Any disclosure of information has the potential for re-disclosure, and may not be protected by federal confidentiality rules.

• Requests for copies of records may be subject to fees in accordance with applicable law. • If I request release by unencrypted email or another unsecure method, I have been warned of and accept the security risks to the information associated with the unsecure transmission, and Merk Child and Family Behavioral Health is not responsible for breach notification or liable for disclosures that occur in transit.

Print Client Name/Authorized to Sign for Client Signature of Client

Relationship To Client Date

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Consent for School to Release and Exchange Information

To: (School)

Address:

Phone

Re Name of Child/Youth DOB:

I, (Parent / Legal Guardian) give my consent for you to release information regarding my child to Merk Child and Family Behavioral Health as it pertains to behavioral concerns, student assessments, progress, attendance and IEP records as requested for the purpose of coordination and continuity of care. I also give authorization for Staff at Merk Child and Family Behavioral Health to share information with school personnel as necessary in order to help them assist, understand, accommodate or monitor my son/daughter within the school environment. If there is information I prefer the provider not to share, I recognize that it is my responsibility to make that known to him/her. This consent shall remain in effect for one year unless I revoke it in writing.

Signature of Parent / Legal Guardian Date