Journey to Change Counseling

catandersonlcsw@gmail.com **(570) 939-7407**

Welcome to Journey to Change Counseling! Here are some forms and information that you will need to fill out to let you know what to expect, what your rights are, and to let me get to know you a bit before we get started.

In this document, you will find:

Client Information Form
Telehealth Consent Form
Good Faith Estimate Form
HIPAA Notice of Privacy Rights
Mandatory Disclosure Form

Journey to Change Counseling

catandersonlcsw@gmail.com (570) 939-7407

Client Information Form

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask questions if something is not clear. The information provided on this questionnaire is confidential and will not be released without your permission.

Basic Information

Client Name (please include maiden name if applicable) _____

Address _____ City/State_____ Zip_____

Home Phone _____ OK to leave messages? Yes No

Work Phone _____ OK to leave messages? Yes No

Cell/Other # _____ OK to leave messages? Yes No

Date of Birth _____ Age _____ Ethnicity _____

Gender: _____ Relationship Status_____

Employment/Occupation (self or parent(s))_____

Income _____ Per _____ Insurance_____

Religious/Spiritual Affiliation: _____

Emergency Contact Information

*In case of an emergency, please list the name, address, and phone number of **two** people that are **not** in therapy with you that I would be able to contact.*

Contact #1:

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

Contact #2:

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

Please sign below, giving your consent to allow your therapist to contact these individuals in an emergency situation as deemed so by your therapist.

Signature: _____Date: _____

If applicable, please list all family members currently residing in your household:

Name of Family Members	**Age**	**DOB**	**Relationship to Client**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many people live in your home, including yourself? _____

Medical History

Please answer the following questions to the best of your knowledge

Physician _____ Approximate Date of Last Visit _____

Current Medications/Dosages _____

Significant Medical Conditions _____

Please list the type and amount of alcohol or drugs used currently: _____

_____

Additionally, please describe any past or current problems with alcohol or drug abuse (including

attempts to quit or cut down, past treatment, arrests, DUIs, etc.) _____

_____

Have you/your child previously received any psychiatric, psychological, and/or counseling help? Yes No

If yes, please describe briefly _____

_____

Other Relevant Information

If applicable, what is the name, age, and gender of your current spouse or partner?

Name: _____ Age: _____ Gender: _____

Do you feel safe in your current relationship?

Physically: Yes No

Emotionally: Yes No

Do your arguments escalate out of control? Never Rarely Occasionally Very Often

Please list and describe any significant family events you would like for me to know about (i.e., deaths,

moves, divorce, etc.): _____

_____

_____

_____

Briefly describe your reason for seeking help _____

_____

_____

_____

Who suggested you contact me? _____

Please circle any of the following concerns you, your child, or your family may be experiencing:

Nervousness	Toileting	Suicidal Thoughts
Shyness	Depression	Finances
Separation/Divorce	Sexual Problems	Unhappiness
Drug Use	Alcohol	Work
Anger	Self Control	Tiredness
Sleep	Stress	Ambition
Relaxation	Headaches	Decision Making
Legal Matters	Memory	Concentration
Energy	Insomnia	Health Problems
Loneliness	Feeling Inferior	Marriage
Education/School	Nightmares	Death of Loved One
Behavioral Problems	Appetite/Eating	Marital Problems
Temper	Parenting	Stomach Trouble
Children	Fears	Thoughts

Other: _____

Please add any additional information that you feel may be helpful to me:

_____

_____

Thank you for completing this questionnaire!

Journey to Change Counseling

catandersonlcsw@gmail.com (570) 939-7407

Telehealth Consent

Some services may be available by telehealth. This consent explains telehealth care. If you have any questions, please ask.

1. **Telehealth/teletherapy:** Telehealth, or teletherapy, involves transmission of video or digital photographs of me, and/or details of my health ("Transmitted Data"). All Transmitted Data is sent via electronic means to my provider(s) to facilitate health care services. I understand that:

   - Telehealth is different from traditional care in that the patient and provider do not meet in-person. It involves interaction between a provider in one location and a client in another location.
   - Patients and providers must inform each other of persons other than the patient and provider who are present, seen or unseen.
   - Patients have the right to refuse or stop participation in telehealth services at any time and request an in-person appointment, however, equivalent in-person services might not be available at the same location or time as telehealth services. Refusal will not affect rights, if any, to future care or treatment. If at any time I desire an in-person appointment, I will notify my provider.
   - Patients have the right to follow-up with their provider as necessary with questions or concerns.
   - Benefits of telehealth include: providers can continue services when an in-person appointment is not possible or is inconvenient, minimized exposure to illness, and visualization of environment.
   - There are also risks involved in telehealth including, without limit, losing the ability to:
     - read physical, visual, or vocal cues/tones and facial expressions, or view the client in person;
     - have physical access to the client in the event of an emergency/crisis or provide physical services.

     Additionally, technical issues may disrupt the visit. There are also risks to preserving confidentiality including a risk that communications may be overheard or accessed by unknown third-parties.
   - Patients have access to information resulting from telehealth services as provided by law.
   - In the event of a technology failure during telehealth services, I should contact my provider at: (570) 939-7407.
   - Health insurance coverage may not exist for psychotherapy services that are provided through technological means.
   - **Telehealth is not appropriate for emergency health care services**. **It is not a substitute for in person or emergency healthcare services. If at any time I am experiencing an emergency, I should contact 911.** My provider may refer me for emergency services and an emergency plan may be provided by my provider.

(cont'd)

2. **Confidentiality:**

- Confidentiality protections required by law or regulation apply to telehealth services.
- Although confidentiality extends to communications by text, email, telephone, videoconference and other electronic means, providers cannot guarantee that communications will be kept confidential and/or that a third-party may not gain unauthorized access. With electronic communication, there is always a risk that communications may be compromised, unsecured, and/or accessed by a third-party.
- To help maintain confidentiality when engaging in electronic health services, it is important that all sessions be conducted in a confidential place. Do not have sessions in public places or in a room where others are present.
- Patients must obtain written permission before recording any visit and may not publish visits.

I have read and agree to the terms in the Telehealth Consent. I understand that telehealth is not a substitute for in person health care services. I understand that telehealth is not appropriate if I am experiencing an emergency health condition. In case of emergency situations, I will contact 911.

_____ Date _____/_____/_____

Printed Name

_____

Signature

Journey to Change Counseling

catandersonlcsw@gmail.com

(570) 939-7407

Provider EIN # 82-2712966

Provider NPI# 1164890554

Date: _____

GOOD FAITH ESTIMATE

Patient Name:	
Patient Date of Birth:	
Patient Address:	
Patient Phone #:	Patient Email:
Patient Diagnosis (if known/applicable):	
IMPORTANT: A formal diagnosis may occur after a diagnostic assessment has been completed. Your therapist will discuss, as relevant, diagnosis(es) as applicable to treatment. **It is within your rights to decline a formal diagnosis.**	

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who is insured but does not plan to use their insurance benefits to pay for health care items and/ or services.

The Good Faith Estimate works to show the cost of items and services that are reasonable expected for your mental health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

Good Faith Estimate
This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The one-time fee for an initial diagnostic assessment is **$200 (CPT Code 90791)**.
Beyond this, the fee for a traditional **50-minute psychotherapy session** (in-person or via telehealth) is **$150 (CPT Code 90834)**. Most clients will attend one psychotherapy visit every 1-2 weeks, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than that, depending upon your individual needs and preference. If it is determined that ninety (90) minutes sessions are necessary, they will be billed at $200 per session. Other length session will be discussed, and the price determined at that time.
It is also important, when determining your total estimate, to take into consideration vacations, holidays, emergencies, and sick time.
You may project any potential future cost(s) by multiplying the session fee of **$150** by the total number of sessions. This will result in your total estimated cost for mental health service(s).
In example, $150 session fee X 4 sessions =$600.
If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

Journey to Change Counseling recognizes every client's therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/ or a new "Good Faith Estimate" will be issued should the frequency of session(s) or needs change. As related, you may request a new GFE at any time in writing during your treatment.

Good Faith Estimate Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Your provider may recommend additional services that are not reflected in this Good Faith Estimate.

The Good Faith Estimate is only an estimate—actual items/ service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events. You could be charged more if complications or special circumstances occur. Other potential items and/ or services associated with therapy charges may include but is not limited to no show/ late cancellation fee(s), record request(s), letter writing(s), legal fee(s)/ court attendance(s), professional collaboration(s), and in-between session supports). These potential items / services and associated fee(s) are discussed further within the Informed Consent documentation and should these items / services be initiated a new Good Faith Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

For questions or more information related to the Good Faith Estimate, visit www.cms.go/nosurprises or call (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place.

With my signature for this Good Faith Estimate, I acknowledge that I am not obligated or required to obtain any of the listed services from this provider and that I am consenting of my own free will, free from coercion or pressure. I also understand that:

- I am giving up some consumer billing protections under federal law.
- I agree to pay for out-of-network care provided by **Journey to Change Counseling.**
- I may get a bill for the full charges for these items and services or must pay out-of-network cost-sharing under my health plan.
- I was given notice explaining that my provider and/or practice is not in my health plan's network, the estimated costs of services, and what I may owe if I agree to be treated by this provider and/ or practice.
- I have received notice both verbally and written/ electronically.
- I fully and completely understand that some or all amounts that I pay may not count towards my health plan's deductible, co-pay, co-insurance, or out-of-pocket limit.
- I can end this agreement by notifying the provider and/ practice in writing before receiving items and/or services.

IMPORTANT: You are not required to sign this form; however, if you do not sign, the provider and/ or practice may not treat you. You have the right to choose to get care from a provider and/or practice that is within your health plan's network.

_____	_____	_____
Print Name	Signature	Date

Journey to Change Counseling

catandersonlcsw@gmail.com (570) 939-7407

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL [INCLUDING MENTAL HEALTH] INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

During the process of providing services to you, **Catherine Anderson** will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

USES AND DISCLOSURES OF PROTECTED INFORMATION

General Uses and Disclosures Not Requiring the Client's Consent. I will use and disclose protected health information in following ways:

Treatment. Treatment refers to the provision, coordination, or management of health care [including mental health care] and related services by one or more health care providers. For example, myself or any staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

Payment. Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. For example, I will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment. If you are covered by Medicaid, information will be provided to the State of Colorado's Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.

Health Care Operations. Health Care Operations refers to activities undertaken by myself that are regular functions of management and administrative activities. For example, I may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning, and accreditation, certification, licensing and credentialing activities.

Contacting the Client. I may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

*Required **by** Law.* I will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when required to report certain communicable diseases

and certain injuries; and (f) when a Coroner is investigating the client's death.

Health Oversight Activities. I will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, and regulatory programs or determining compliance with program standards.

Crimes on the premises or observed. Crimes that are observed by myself that are directed toward myself, or occur on the office premises will be reported to law enforcement.

Business Associates. Some of the functions of my business are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

Research. I may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed.

Involuntary Clients. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

Family Members. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

Emergencies. In life threatening emergencies I will disclose information necessary to avoid serious harm or death.

Client Authorization or Release of Information. **Catherine Anderson** may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

YOUR RIGHTS AS A CLIENT

Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information I have regarding you, in the designated record set. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask me for the appropriate request form.

Amendment of Your Record. You have the right to request that I amend your protected health information. I am not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask me for the appropriate request form.

Accounting of Disclosures. You have the right to receive an accounting of certain disclosures I have 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. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask me for the appropriate request form.

Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health

information. I do 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. To make a request, ask for the appropriate request form.

Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information by alternative means or at alternative locations. For example, if you do not want me to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask for the appropriate request form.

Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

ADDITIONAL INFORMATION

Privacy Laws. It is required by State and Federal law to maintain the privacy of protected health information. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.
Terms of the Notice and Changes to the Notice. I am required to abide by the terms of this Notice, or any amended Notice that may follow. I reserve the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in my service delivery sites and will be available upon request.

Complaints Regarding Privacy Rights. If you believe I have violated your privacy rights, you have the right to complain. To file your complaint, you must file in writing by mail, fax, e-mail or via the OCR Complaint Portal

You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

It is my policy that there will be no retaliation for your filing of such complaints.

Journey to Change Counseling

catandersonlcsw@gmail.com (570) 939-7407

INFORMED CONSENT TO TREATMENT AND DISCLOSURE STATEMENT

1. **INFORMATION**

Name: **A. Catherine Anderson**
Address: **Montrose, CO**
Phone: **(570) 939-7407**

2. **CREDENTIALS**

Licensure: **CO CSW0.9925757, PA CW13425, NC CO11971**
Degrees: **BS, MSW**
Professional Experience: **CBT, ACT, Brainspotting, Trauma Informed Approach**
Certifications: **Psychedelic Assisted Therapy**

3. **REGULATION OF PSYCHOTHERAPY**

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals in the state of Colorado are listed below.

- **Psychology:**
  - A Licensed Psychologist must: (1) hold a doctorate degree in psychology; (2) have one year of post-doctoral supervision; and (3) pass a written examination in psychology and a jurisprudence examination.
  - A Psychologist Candidate must have completed a doctoral degree from a graduate school of psychology and be in the process of completing the required supervision for licensure.
- **Marriage and Family Therapy**
  - A Licensed Marriage and Family Therapist must: (1) hold a master's or doctorate degree in marriage and family therapy; (2) have at least two years of post-master's practice or one year of post-doctoral practice in individual, couple, and family therapy, including at least 1,500 hours of face-to-face direct client contact as determined by the Board; and (3) pass a written examination in marriage and family therapy and a jurisprudence examination.
  - A Marriage and Family Therapist Candidate must have completed a master's or doctoral degree from an accredited school or college in marriage and family therapy and be in the process of completing the required supervision or licensure.

- **Social Work**
    - A Licensed Social Worker must: (1) hold a master's degree in social work; and (2) pass an examination in social work and a jurisprudence examination.
    - A Licensed Clinical Social Worker must: (1) hold a master's or doctoral degree from a graduate school of social work; (2) have practiced social work for at least two years under the supervision of a licensed clinical social worker or other person with equivalent experience as determined by the Board; and (3) pass an examination in social work and a jurisprudence examination.
    - A Clinical Social Worker Candidate must have completed a master's or doctoral degree from a graduate school of social work and be in the process of completing the required supervision for licensure.
- **Professional Counseling**
    - A Licensed Professional Counselor must: (1) have at least two years of post-master's practice or one year of post-doctoral practice in licensed professional counseling under clinical supervision; (2) have at least 2,000 hours of practice in counseling, including at least 1,500 hours of face-to-face direct client contact under clinician supervision; (3) and pass an examination in professional counseling and a jurisprudence examination.
    - A Professional Counselor Candidate must have completed a master's or doctoral degree in professional counseling from an accredited school or college, which degree or program must include a practicum or internship in the principles and the practice of professional counseling, and be in the process of completing the required supervision for licensure.
- **Addiction Counseling**
    - A Licensed Addiction Counselor (LAC) must: (1) have completed a master's or doctoral degree in the behavioral health sciences from an accredited school, college, or university; (2) have completed 3,000 hours of supervised experience in addiction counseling with a minimum of 2,000 direct clinical hours; and (3) have passed the master addiction counselor examination and a jurisprudence examination.
    - A Certified Addiction Counselor (CAC) must have met the requirements for certification as a certified addiction technician or a certified addiction specialist.
    - A Certified Addiction Technician (CAT) must: (1) have a high school diploma or its equivalent; (2) have accrued at least 1,000 hours of supervised clinical experience hours over a minimum of six months; and (3) passed the national certification addiction counselor level I examination and a jurisprudence examination.
    - A Certified Addiction Specialist (CAS) must: (1) have a bachelor's degree in a behavioral health concentration or human services equivalent; (2) have accrued at least 3,000 hours of supervised clinical work hours over a minimum of 18 months; and (3) have passed the national certification addiction counselor level II examination and a jurisprudence examination.
    - An Addiction Counselor Candidate must have completed a master's or doctoral degree in the behavioral health sciences form an accredited school, college, or university and be in the process of completing the required supervision or licensure.

4. CLIENT RIGHTS AND IMPORTANT INFORMATION

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. The therapists provide non-emergency psycho-therapeutic services by scheduled appointment only. If one of the therapists believes your psychotherapeutic issues are above his/her level of competence or outside of his/her scope of practice, the therapist is legally required to refer, terminate, or consult. If, for any reason, you are unable to contact your therapist by telephone, and you are having a true physical or mental health emergency, please dial 911, go to your nearest emergency room, or call Colorado's Crisis Hotline (844) 493-8255. If you must seek afterhours treatment from any counseling agency, center, emergency room, hospital or similar facility, you are solely responsible for any fees due.

d. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies or registers the therapist.

e. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incidents of child abuse or neglect to law enforcement; (2) I am required to report suspected incidents of at-risk adult or elder abuse, exploitation, mistreatment, and/or self-neglect; (3) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (4) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (5) I am required to report any suspected threat to national security to federal officials; and (6) I may be required by Court Order to disclose treatment information.

f. There may be times when your primary therapist may need to consult with a colleague or another professional such as an attorney or supervisor, about issues raised by you in therapy. Your confidentiality is still protected during consultation by your primary therapist and the professional consulted. Only the minimum amount of

information necessary to consult will be disclosed. Signing this disclosure statement gives your primary therapist permission to consult as needed to provide professional services to you as a client. You will need to sign a separate Authorization for Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney retained by your primary therapist.

g. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.

h. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA standards.

i. I maintain client records for seven years from the date of termination of services or the last date of contact with the client, whichever comes later. However, if the client is a minor, I maintain records for seven years from the last date of treatment or when the child reaches 18, whichever comes later.

j. I agree not to record our sessions without your written consent; and you agree not to tape or record a session or a conversation with me without my written consent.

k. Although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access the communications. Even though I utilize current encryption methods, firewalls, and back-up systems to help secure communications, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Emails and texts, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Faxes can easily be sent erroneously to the wrong address. Please limit communication by text or email to administrative purposes only and do not use them as an avenue for therapy. NEVER use email or text for emergencies. Please note that the business numbers for all of the therapists are cell phone numbers.

l. In therapy where a family is the "client," the therapist holds a "no secrets" policy. All members of the family are treated equally and secrets are not kept that require differential or discriminatory treatment of family members. This means that there may be times when individual sessions would be beneficial to the therapeutic process in the course of family counseling. If your therapist meets with one or multiple members of the family in individual sessions, the contents of those meetings will likely be shared with the non-attending members at the next group/family session. The information shared in individual sessions is not confidential from the other participating members. Should you reveal information that may be harmful to other participating members and you refuse to disclose the information, therapy services, among other things, may be terminated. Your primary therapist may choose to disclose information revealed in the individual sessions if they, in their sole discretion, determine that the information must be disclosed for therapy to be effective. If appropriate, your primary therapist will give you the opportunity to disclose the information first. However, your primary therapist will not lie or refuse to answer any question posed by the other family members. Should you feel it is necessary to disclose something to your primary therapist and keep that information confidential, your primary therapist can refer you to another therapist who can treat you individually. Please be aware that information you choose to share with your primary therapist that is particularly pertinent to all participating members of the family may come out in counseling. This pertains to all face-to-face, written, and phone conversations and messages. Your primary therapist cannot be subpoenaed to testify or produce records without consent and authorization from all participating members of the family.

m. This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Consistent with HIPAA guidelines, authorizations for release and consent for treatment will be automatically revoked one year after signing date.

(cont'd)

5. DISCLOSURE REGARDING DIVORCE OR CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. Forcing me to testify undermines the therapeutic relationship with your child, causes significant feelings of betrayal and mistrust, and may cause significant long-lasting trauma for your child. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

6. ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

I have read the preceding information, and it has been presented to me verbally. I understand my rights as a client or the parent/legal guardian of a client. By signing below, I acknowledge my understanding to all the terms discussed in this disclosure statement. I also affirm, by signing this form, that I am the patient or the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children for whom I am requesting psychotherapy services. I also affirm, by signing this form, that, if applicable, I have read and understood, the No Surprises Act Notice Form that was provided to me and verbally explained to me, and I understand that I have the right to request a Good Faith Estimate at any time from the provider.

Client's Name: _____

_____

Client Signature (Only sign if 12 years old or older) Date

Parent/Legal Guardian Signature (if applicable) Date

_____

Parent/Legal Guardian Signature (if applicable)
