

STATEMENT OF DISCLOSURE AND INFORMED CONSENT

1. As a client of mine, I want you to be fully informed of my experience and credentials.

I hold a degree of Master of Arts in Transpersonal Counseling Psychology, concentration in Art Therapy, from Naropa University, Boulder, CO (2004) and hold a Bachelor of Fine Arts, received from the School of the Art Institute of Chicago, Chicago, IL (2001).

I am a Licensed Professional Counselor in the state of Colorado (CO License #4904).

I am a Certified Internal Family Systems Therapist in accordance with standards set by the IFS Institute (CSL-0810).

I am a Registered Art Therapist as conferred by the American Art Therapy Association (ATR #13-153). I maintain professional memberships in the American Art Therapy Association and the Art Therapy Association of Colorado.

Because of my training and clinical experience, my theoretical orientation is Transpersonal. I work from an Integral framework, employing theory and methodology of Internal Family Systems (IFS), Psychodynamic, Cognitive/Behavioral, Transpersonal, and Experiential/Art Therapies.

2. The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite #1350, Denver, Colorado 80202, 303-894-7766.

3. Client rights and important information:

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

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

c. 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 Department of Regulatory Agencies, Mental Health Section.

d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. There are exceptions that I will identify to you as the situations arise during therapy.

4. There may be times when I may need to consult with a colleague or another professional, like an attorney, about issues raised by clients in therapy. Client confidentiality is still protected during consultation by me and the professional consulted. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.

5. The fee for a standard 50-minute psychotherapy session is \$190, and the fee for an extended 80-minute psychotherapy session is \$275. I may be able to provide a negotiated sliding scale for persons paying for their own therapy, who have a financial need. Payment is due in full at the end of each session. Payment can be made by cash, check, or credit card (Visa, MasterCard, and Discover). If you write a check it is expected that the check can be cashed. If the check is cashed and bank charges are incurred for a bounced check, there will be a charge of bank fees times two.

6. The time of your scheduled appointment is reserved for you. If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance; earlier notification is appreciated. It is my policy to charge for cancellations received with less than 24 hours notice.

7. Regarding closure and termination: Individual sessions are either 50 or 80 minutes. Closing a session is an important part of therapy and a continued going over-time signals a therapeutic issue. Termination from therapy is an essential part of the therapeutic process. If at any point during the therapeutic process I assess that I am not effective in helping you reach therapeutic goals I am obligated to discuss this and to possibly terminate therapy. If this should happen, I will provide appropriate referrals and offer support during the transition period. As a client of mine you have the right to terminate therapy at any time and I will help you find someone qualified and to your liking if you want to continue therapy. Should you wish to finish your psychotherapy with me, it is appreciated if you make a verbal notification so we can allow for an appropriate closure. It is typical that several months of therapy require a few sessions to finalize and close our relationship. If our work has been several months or several years, additional sessions are needed to appropriately close the therapeutic relationship.

8. There is no fee for brief phone consultations outside of sessions that are 10 minutes or less. Any telephone time over 10 minutes is charged on a pro-rated basis. I check my voicemail regularly during business hours on weekdays and return messages within 24 hours whenever possible. Should a crisis arise outside of regular business hours (10am-7pm) and you are in need of immediate support and you are unable to reach me by phone, please leave me a voice message and place a call to a friend, emergency services (911), or go to the nearest hospital emergency room. I do offer urgent sessions under specific situations and at your request.

9. Under the federal No Surprises Act (HR133, Title 45 Section 149.610), health care providers need to give clients who don't have certain types of health care coverage, or who are not using certain types of health care coverage, a "Good Faith Estimate" of what the charges could be for psychotherapy services before those services are provided.

The fee for a standard 50-minute psychotherapy session is \$190, and the fee for an extended 80-minute psychotherapy session is \$275. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. The 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 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.

If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.

10. If you have any questions or would like additional information, please feel free to ask during the initial session and any time during the psychotherapy process.

I have read the preceding information and understand my rights as a client. By signing below, I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my therapist to seek consultation with other psychotherapists or professionals as the need arises. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children that I am requesting psychotherapy services for.

Client Signature
(Parent or Guardian for a Minor)

Date

Therapist Signature

Date