DISCLOSURE STATEMENT / CONSENT TO DO THERAPY

1. **Information:** Amy Bishop, M.S., LMFT, Springs Therapy LLC, 313 N Tejon Street, Suite 7, Colorado Springs, CO 80903, (719) 822-2066 (Therapist).

2. **Credentials:** Therapist graduated from Colorado State University with a Master of Science degree in Human Development and Family Studies with an emphasis in Marriage and Family Therapy, and is a Licensed Marriage and Family Therapist within the state of Colorado.

3. **Regulation of Psychotherapists:** The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. Regulatory requirements applicable to mental health professionals are as follows:

The state regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a **Licensed Marriage and Family Therapist**, and a Licensed Professional Counselor must hold a Masters degree in their profession and have two years of post-Masters supervision. A Licensed Psychologist must hold a Doctorate degree in psychology and have one year of post-Doctorial supervision. A Licensed Social Worker must hold a Masters degree 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 Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical Masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, and is not licensed or certified.

4. **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, 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. 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 State Licensing Board.

d. Generally speaking, the information provided by and to the client in a professional relationship with therapist is **legally confidential** and therapist cannot disclose the information without client's consent. There are several **exceptions to confidentiality** which include: (1) I am *required* to report any suspected/known incident of **child abuse** (even if victim is an adult now if there's knowledge/reason to believe that perpetrator is in position of trust (clergy, teacher, parent), or **elder (70yo+) abuse or neglect**, even if it's already been reported; (2) I am *required* to make reasonable and timely effort to report any serious threat of **imminent physical violence** against a specific person(s), including specific location/entity to law enforcement and to the person(s) threatened; (3) I *may* report to school/district and law enforcement an articulable and significant threat or substantial harm against a school or occupants or exhibits such behaviors; (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, which may include a call to CO Crisis Support Line for a mobile evaluation which may result in a 72-hour hold, which I will not be liable for; (5) I am *required* to report any suspected **threat to national security** to federal officials; (6) I may be required by **Court Order** to disclose treatment information; and (7) I am *urged* to report to a county department reasonably believed or observed incidents or imminent risk of mistreatment (abuse, caretaker neglect and/or exploitation), and/or self-neglect of at-risk adults and elders not more than 24 hours after observation or discovery; IDD to law enforcement agency. You may read section 12-43-218, 18-3-401(3.5), 18-6.5-108, 19-3-304(1), 26-5-111, and 27-65-105 of the Colorado Revised Statutes C.R.S 25-1-802, and the HIPAA Privacy Rule Federal law 45 C.F.R 164.501 for further details. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf.

e. 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.

f. 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.

g. If you have complaints or concerns about the way that you have been treated or the services you have received, you may speak directly with me and/or file a grievance with the **State Grievance Board at 1560 Broadway, Suite #1350; Denver, CO, 80202; (303) 894-7766**. Please note that you must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered any ethical or legal violation. When the client is a minor child, you may file a complaint before the child turns 18 years old, or within 7 years, or whichever comes later. Pursuant to this law, Therapist will maintain records for a period of seven years commencing on the date of termination of services, or on the date of last contact with the client, whichever is later.

5. **By Signing this Statement client agrees and understands:**

a. **Office Hours.** I check my messages and return calls/emails Monday through Friday during normal business hours. I do not provide on-call emergency services**.**

b. **Emergency.** In the event of a crisis/emergency call 911 or go to the nearest hospital emergency room and seek immediate medical or psychiatric attention. If currently considering or threatening suicide or any form of harm to myself or others, client takes full responsibility for seeking appropriate local help immediately and for any action client may take. Client acknowledges the following resources: **www.hopeline.com**

1-800-273-TALK(8 25 5) 24hour Suicide Prevention Lifeline	1-800-SUICIDE	1-800-656- HOPE	1-800-TLC -TEEN	844-493-TALK(8255) text TALK to 38255 CO Crisis Support Line

c. **E-mail**. E-mail is for scheduling purposes only. Please protect your privileged and private confidential information by not texting or e-mailing it. Emails are retained in your client log as well as the logs of your and my Internet service providers and available to be read by their system administrator(s). **Technology such as these are not confidential**. When emailing, please CC all involved family members. To consent to sending and accepting texts for scheduling purposes, you recognize the risk that information could be exposed to others when it appears on your phone.

d. **Social Media.** I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc) to avoid compromising confidentiality and to keep the boundaries of our therapeutic relationship. Liking or following my professional Facebook page is optional, though it may risk confidentiality.

e. **Therapist Feedback/Reviews**. Posting a review, testimonial, rating or endorsement is voluntary, not requested, and may risk confidentiality of treatment. I cannot respond to any review, even those under a pseudonym, due to confidentiality, and I may never see them. Please communicate anything about therapy or therapist directly in session, even if you decide we are not a good fit.

f. **No Secrets Policy.** In the case of family therapy, and particularly couples' therapy, Therapist practices a "no-secrets" policy, meaning therapist may not keep secrets from other family members/partners unless it is believed that revealing the secret will endanger client.

g. **Consultation.** In keeping with generally accepted and standards of practice, and with the purpose to assure quality care, therapist receives clinical supervision and will confidentially consult with other mental health professionals, i.e. regarding case management. A working list of names of professionals whom I may consult with can be provided.

6. **DISCLOSURE REGARDING DIVORCE AND 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. 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. If you subpoena me or records I will obtain an attorney to oppose it in order to preserve the extremely important therapeutic relationship. Harm may result in the clinical relationship when MFTs are forced to testify and to share treatment information regarding their children clients. If children client's confidentiality is betrayed it may risk loss of therapeutic alliance and trust.

7. **METHODS AND TECHNIQUES**

Therapist integrates trauma-informed systemic therapies including PACT (Psychobiological Approach to Couple Therapy), AEDP (Accelerated Experiential Dynamic Psychotherapy), Gottman Method, Cognitive Behavioral Therapy, Emotionally Focused Therapy, Solution-Focused Therapy, Narrative and Collaborative Therapies, Motivational Interviewing, and other techniques with a strengths-based approach, utilizing an evidence-based treatment modality appropriate to the client and presenting issues. Therapist is trained in AEDP level I, Gottman Level I and II, PACT Level 2, and Trauma Focused- CBT. Duration is determined by need and measured progress.

You are entitled to develop your goals and Treatment Plan and learn of the benefits and risks associated with the particular approach, and anticipated frequency, with no absolute guarantee of your desired results by your therapist as it is hard to predict the outcome of therapy.

8. **RESPONSIBILITIES, PAYMENT FOR THERAPY FINANCIAL AGREEMENT**

As the financially responsible person for the account you are ultimately responsible for all fees described in this agreement and will pay for all portions of services, due in full at the time services are provided by therapist. Payment methods accepted: Cash, Check, electronic transfer, debit or credit card via Square. Change is not given for payments and any positive balance will be applied to your next session's balance. A $25 NSF insufficient fund charge is assessed for returned/declined checks/payments, and checks that are not paid within 2 weeks of being returned to Therapist's office are handled as unpaid bills. Unpaid bills may be submitted to collection services, credit reports, court, and the local district attorney's office. In persistent cases a discharge from the practice may be appropriate for nonpayment situations. You may be charged for phone consults of 10 minutes and more with Therapist based on the standard rates below with a minimum 30-minute rate.

Please note**: Any payment not by cash may not be HIPPA compliant**.

9. **LATE CANCELLATION/NO SHOW/TERMINATION POLICY AGREEMENT**

You shall keep all scheduled appointments, unless a personal emergency occurs, and shall give notice of at least 24 hours of intention to cancel your appointment. If you leave a message, the date and time of the message will serve as the basis of when notice was made. Cancellation fees are as follows:

- If appointment is cancelled 24 hours in advance, or earlier: no penalty
- Cancellations 2-24 hours in advance of session (LATE CANCEL): **$50**
- Cancellations of less than two hours will be considered a "NO SHOW"- you will be charged a **full session fee**.

Grace is always given for sickness and unsafe weather/road conditions **with advance notice**, and emergencies (determined by therapist). You are responsible for letting the therapist know of the emergency and for scheduling the next appointment. If you do not respond within a month, therapist will document termination of therapy. Therapist reserves the right to terminate therapy when appropriate and ethical.

By signing this agreement, you are legally accepting responsibility to pay for the late cancellation or no show fee.

10. **THERAPIST FEES**

	Service Rate
30 min (phone consult)	55
55 min (Individual/family or by request)	120
85 min (couple or by request)	175

It is possible that fees may raise in the course of your treatment. Fees will not increase more than once per year, and will not exceed a 10% increase. If a fee increase does occur, and it hinders your participation in therapy, please proactively bring this to the therapist's attention.

11. **TREATMENT AGREEMENT CONSENT AND AUTHORIZATION**

By signing below I agree to abide by these accepted terms of service regarding treatment, disclosure, payment, privacy, late cancellations/no show, fees, billing, and rights. I authorize Therapist to provide psychotherapy assessment and/or mental health treatment/services to me as a client/consumer.

I have read all the information herein and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement if requested. I know my rights as a client or as the client's responsible party.		
Print client's name	Client's or Responsible Party's **Signature**	**Date**
If signed by Responsible Party, please state relationship to client and authority to consent:		

A) **Minor 12 years or older** have authority to consent to treatment on their own behalf (CRS 27-65-103).

B) **Minor under 12 years old**, PLEASE CHECK BOX INDICATING marital status of parents:

- ❑ Married (Need either parent's consent)
- ❑ Never married, never a court order appointing decision-maker (Need either parent's consent)
- ❑ Divorced/Court Order establishing allocation of parental responsibilities/decision-making **Need copy**
  - ❑ Parent with Decision-Making for medical and/or mental health decisions is privilege holder and can consent **OR**
  - ❑ Joint Decision-Makers (Need **both** parents' consent)

Any parent is entitled to receive a treatment summary of services given/needed with or without 1) decision-making authority (CRS 25-1-802) or 2) consent of the minor.

Provider Statement

Therapist hereby personally and professionally commits to offering you these rights, providing you with the highest quality of service and responding to your needs in the most highly ethical manner, according to the professional standards of care in marriage and family therapy.

Therapist's Signature: _____ Date: _____

Amy Bishop, M.S., LMFT, 313 N Tejon Street, Suite 7, Colorado Springs, CO 80903