Counseling Colorado, PLLC
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Disclosure Statement

Degrees, credentials, certifications, registrations and licenses held by your counselor, Lauren Hughes:

Masters Degree in Counseling - Regis University, Chi Sigma Iota Graduate Counseling Honors (2010)
Bachelor of Arts Degree in Communications - The University of Boulder at Colorado (2004)
Colorado Registered Psychotherapist Database
Licensed Professional Counselor (LPC)
Nationally Certified Counselor (NCC)
Licensed Addictions Counselor Candidate (LAC)

Statement of Trade Name of an Individual, Counseling Colorado, is filed with the state of Colorado pursuant to 7-71-103 of the Colorado Revised Statues (C.R.S.)

About My Client Rights:

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Colorado Department of Regulatory Agencies(DORA). The Board of Mental Health Examiners can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7800.
A Licensed Marriage and Family Therapist, (LMFT), and a Licensed Professional Counselor, (LPC), must hold a master's degree or higher in counseling or the mental health field and have completed over 2,000 hours of clinical supervision. Also, and LPC must pass the (NCE), National Counselor Examination.
Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements, have 3,000 hours of supervised addiction counseling experience, and pass the (MAC), Master Addictions Counselor Examination with Co Occurring Disorders.

Client Rights and Important Information:

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.

You may seek a second opinion from another therapist or terminate therapy at any time.
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 (DORA) at (303) 894-7800.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to the confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, Federal regulations governing

Confidentiality and Drug Abuse Patient Records 42. C. F. R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. pts 160 & 164.

There are legal exceptions to the general rule of legal confidentiality. The exceptions include: (1). intent to harm others or yourself; (2). abuse or suspected abuse of children, and possibly the abuse of the elderly or others unable to care for themselves; (3). neglect or suspected neglect of children; (4). subpoenaed testimony in criminal court cases. Also be aware, that exception in the case of information given to a licensed psychologist, licensed marriage and family therapist or licensed professional counselor, legal confidentiality does not apply in a criminal or delinquency proceeding. Also confidentiality does not apply in professional consultation or referrals to other mental health professionals. There are other exceptions, which I will identify to you as the situations arise during therapy. The Mental Health Practice Act (CRS 12-43-101,) et seq.) is available on the DORA website.

Fees and payments

Clients are seen on a fee-for-service basis only. The client/legal guardian is responsible for payments in full at the time of each session. The charge is $150 per clinical hour for individual sessions and $200 per clinical hour for couples or family sessions. Psychotherapy is provided in a 45-50 minute clinical hour instead of a 60 minute clock hour. Blocked rates are offered and may be determined on an individual basis. Our policy is for each person receiving counseling services to pay for such services at the time the professional services are rendered. Clients arriving late to their designated appointment time will be charged full session fees. Any other arrangements must be made in advance.

As A Psychotherapy Client, I Understand That:

I_____, understand that court testimony on my behalf, is charged at a higher rate of $ 300.00 per hour (a minimum of 4 hours) including testimony related to matters like case research, report writing, travel, depositions, actual testimony and cross examination time and courtroom waiting time. Signing this disclosure statements gives permission for my therapist to release confidential information in courtroom testimony and written reports to the Courts. Parents / Guardians can not, nor will subpoena Counseling Colorado's notes for custody / parenting time / parental evaluations or any other reason. This includes any notes, progress or process, any Soap or Dap notes. What can be provided is legal testimony or a treatment summary report that includes: Dates of session, summary of treatment plan, diagnosis (if a diagnosis was given), fees for services and outcome at time of termination.

Being called to testify in custody/ parenting time / parental decision making matters can potentially harm the therapeutic process and is not encouraged unless necessary. In the event my testimony becomes necessary for some reason, Counseling Colorado's legal rate will be charged and a subpoena is required. We all agree that the purpose of therapy is to provide a safe environment in which the client (s) may freely express themselves and any issues.

Telephone Calls

Occasionally the need to talk to your therapist may arise between normally scheduled sessions. It is difficult to conduct psychotherapy over the phone, but at times, your therapist may be able to respond to your call during "normal" business hours. A charge will be incurred by the patient for any telephone consultation time between scheduled sessions with his/hers therapist or any therapist covering or filling in for my therapist. The client will be charged in 15 minutes increments at the clients standard hourly rate for phone counseling services. If there is an emergency and your therapist cannot be reached, call 911 or go immediately to your local hospital Emergency Room.

As a client of Counseling Colorado, I understand that there may be times when it is necessary to communicate with my counselor outside of the office setting. Therefore, I,

_____

(Please Print Your Full Name)

Consent to communication with Counseling Colorado in the following ways:
Please initial each area where consent is given.

_____ Voicemail Home
_____ Voicemail Cell
_____ Text Message
_____ Email

I understand that these forms of communicating may not be confidential. By signing below, I give my written consent to these forms of communication.

_____

(Client's Signature)

I understand that there may be times when my therapist may need to consult with a colleague or another professional, like an attorney or medical professionals about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client.

I understand that in marriage, engagement, family or significant other counseling, my therapist holds a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the therapist that require differential or discriminatory treatment of family members. I understand that any information shared in individual therapy MUST also be shared in couple or family therapy to insure this "NO SECRETS" policy. Signing this disclosure statement affirms permission to share this confidential information.

I understand that my therapist provides non-emergency therapeutic services by scheduled appointments. If my therapist believes my therapeutic issues are above her level of competence, or outside her scope of practice, she is legally required to refer, terminate, or consult with other professionals. If, for any reason, I am unable to contact my therapist by phone, and I have a true emergency, I will call 911 or check myself into the nearest hospital emergency room.

I understand that should I have any questions or would like additional information, I am free to ask during the initial session or at any time during the therapeutic process.
By signing this disclosure statement, I also give permission for the inclusion of my partner, spouse, significant other, fiance', parents, legal guardians, children or other family members or close friends in therapy when deemed necessary by myself or my therapist.

I understand that I am legally responsible for payment of my psychotherapy services. Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timeliness to your insurance provider. Services provided are not contracted (in network, preferred provider) with any insurer. A receipt for counseling services can be provided at the time of your appointment to be submitted for reimbursement from your insurance company if you choose. Please note that we do not complete any insurance paperwork.

CANCELLATIONS AND MISSED APPOINTMENTS

When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, (24 hours), the therapist is unable to make use of that time. A fee is assessed regardless of whether or not it is the client's "fault" that the appointment was missed. Therefore, if a 24-hour notice of cancellation is not given, the total session fee will be charged to the client.

FINANCIAL AGREEMENT AND AUTHORIZATION/ CONSENT FOR TREATMENT

I have read the preceding information. It has also been provided verbally, and I understand my rights as a client. In presenting myself (or my child) for evaluation, diagnosis and treatment, I voluntarily consent to the rendering of counseling services provided by Counseling Colorado, LLC. I acknowledge no guarantees have been made or implied to me as to the effect of treatment on my (or my child's) condition. 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 psychotherapist 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 rights to consent to treatment for any minor child or children for which I am requesting psychotherapy services.

_____ _____

Client Signature Date

_____ _____

Custodial Guardian Signature Date

_____ _____

Therapist Signature Date