DISCLOSURE STATEMENT

1. **INFORMATION**

Stacy Mesias, MS, LMFT
6190 Lehman Dr. Suite 106
Colorado Springs, CO 80918
(719) 232-0176

2. **CREDENTIALS:**

Licensure: Licensed Marriage and Family Therapist

Degrees: University of Northern Colorado, 1997, Bachelors in Business Administration, University of Phoenix, 2011, Masters in Marriage and Family Therapy

Professional Experience: Individual, couples and family therapy at the offices of Carol Kryder and therapy with adolescents and families at the Griffith Center for Children, counseling individuals and couples at Fulcrum Counseling, Inc. since 2011

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 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 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 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a Bachelors degree in behavioral health, and 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 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.

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 structure. 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 Department of Regulatory Agencies, Mental Health Section.

d. Generally speaking, the 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 incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) 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; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.

Information disclosed to a licensed psychologist, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, 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.

e. 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.

5. **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.

I have read the preceding information 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.

_____

Print Client's Name

_____ _____

Client Signature Date

If signed by the Responsible Party, identify that party's legal authority to consent to treatment:_____

CLIENT INFORMATION

Name_____ Today's Date_____

Address_____

Best Phone Number_____ Email_____

Age_____ Birth date_____ Marital Status (circle): M S SEP DIV WID

Gender_____ Education Completed_____ Soc Sec #_____

Employer_____ Occupation_____

Who referred you to this office?_____

If self-referred, how did you discover this office?_____

HEALTH HISTORY

Please check any that apply to you, or your family, and indicate the relation:

N/A	Self	Fam		N/A	Self	Fam	
☐	☐	☐	Alcoholism_____	☐	☐	☐	High blood pressure_____
☐	☐	☐	Depression_____	☐	☐	☐	Thyroid problems_____
☐	☐	☐	Suicide_____	☐	☐	☐	Mental illness_____
☐	☐	☐	Other_____				

Yes No

☐ ☐ Are you taking any medication? List all types and duration:_____

_____

☐ ☐ Do you have any health problems? List, including duration:_____

_____

☐ ☐ Have you had medical problems in the past?_____

_____

☐ ☐ Have you ever been admitted to a psychiatric hospital? Specify reason and duration:_

_____

☐ ☐ Have you ever been to counseling before? Specify dates and duration:_____

_____

☐ ☐ Any past or present legal issues:_____

_____

CURRENT INDICATIONS

Main reason for coming to this office. _____

_____

_____

Daily amount used: Alcohol_____
Marijuana_____
Coffee/Cola_____
Cigarettes_____

Please underline any of the following that apply.

Headaches	Inferiority feelings	Marked mood changes
Fainting	Homicidal Ideas	Loneliness
Dizziness	Suicidal ideas	Legal difficulties
Memory problems	Past suicidal attempts	Past court involvement
Irritability	Guilt	Employment problems
Restlessness	Difficulty making decisions	Inadequate income
Anxiety	Unwanted thoughts	Eating disorder
Panic attacks	Brooding	School problems
Thought racing	Preoccupations	Problems with anger
Depression	Compulsions	Domestic abuse
Fatigue	Heart palpitations	Drinking too much
Frequent worries	Problems concentrating	Past drug/alcohol abuse
Poor appetite	Difficulty relaxing	Drug problems
Overeating	Family problems	Vomiting
Weight change	Loss of important relationship	Unusual experiences
Difficulty making friends	Insomnia	Hallucinations
Difficulty keeping friends	Excessive sleep	Difficulty trusting people
Loss important relationship	Nightmares	Paranoid thoughts/feelings

LEVEL OF DISTRESS

Indicate how distressed you are by circling a number on the scale below.
(1 = very little distress; 10 = extreme distress)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts ☐Yes ☐No

Have you experienced suicidal thoughts in the past ☐Yes ☐No

If yes, when? _____

Have you ever attempted suicide ☐Yes ☐No

If yes, when and how_____

Have any of your friends or family ever committed or attempted suicide ☐Yes ☐No

If yes, who and when_____

I wish to be contacted in the following manner:

Telephone number_____

Leave call back information only ☐ or may leave detailed message ☐

Written communication to address:_____

Email address_____

Leave reply and appointment information only ☐ or may write detailed message ☐

Text Message number_____

Leave reply and appointment information only ☐ or may write detailed message ☐

_____

Client Signature Date

OFFICE POLICY AND FEE AGREEMENT

SERVICES

Psychotherapy differs depending on the personalities of the client and therapist and the goals of the client. I may utilize many different methods to help you address your situation. These methods will be discussed with you prior to employing them.

Psychotherapy has benefits and risks. Confronting difficult situations in your life may lead to unpleasant feelings and possible disruption to your life. However, psychotherapy has proven to be beneficial to those who have experienced it. Therapy promotes better relationships, strengthens healthy family dynamics, opens family communication, and reduces feelings of distress.

You should evaluate your comfort with me and psychotherapy. At any time, you may decide that this is not the right choice for you and your family. If therapy has already begun and you decide to discontinue, please discuss this with me first so proper arrangements can be made.

CONFIDENTIALITY

The confidentiality of your records is protected by Colorado State law. If you wish Stacy Mesias to discuss your case with another party, you must complete an Authorization to Release Information. The law requires the release of confidential information in the case of suspected child abuse and potential harm to oneself or others.

CONSULTATION WITH COLLEAGUES

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my clients. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about theses consultations unless I feel that it is important to our work together.

APPOINTMENTS AND CANCELLATIONS

Appointments are scheduled by contacting me directly at 719-232-0176. Sessions are fifty minutes in length unless other arrangements have been made. If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance. Cancellations due to inclement weather will not be charged.

FEES AND PAYMENT

It is customary to pay for services when rendered. You agree to accept full responsibility for payment of any balance incurred for services. The fee is $60 per fifty minute session. If an appointment is canceled within twenty-four hours or missed, the agreed upon fee will still be paid for the missed session.

If you should encounter financial difficulties while in counseling, please discuss your situation with me as soon as possible.

OUTSTANDING PAYMENTS

If your account or your family's account has not been paid for more than 30 days and arrangements for payments have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. The costs of such legal actions will be included in the final claim.

CONTACTING THE OFFICE

Services are only available at scheduled times. If you need to speak with me between regularly scheduled sessions, please call the confidential phone line at 719-232-0176, and I will return your call as soon as possible. Or, feel free to email the office at stacy@FulcrumCounseling.com. There may be situations in which I wait to respond to messages until your next scheduled session.

EMERGENCIES

By signing this document you agree that if, at any point, you experience a mental health emergency you will call 9-1-1 or go to a local emergency room.

Client signature Date