A Child At Heart Therapy LLC

Informed Consent for Treatment and Disclosure Statement

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and let me know of any questions you might have. When you sign this document, it will represent an agreement between us.

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720-236-2070

Degrees:

Metropolitan State College of Denver BA in psychology 2001
University of Denver EdS in school psychology 2005
University of Colorado Denver school administration 2012

Credentials:

Licensed Professional Counselor Candidate, LPCC.0015320, State of Colorado expires 5/21
Colorado Department of Education School Psychology License #7992 7/21
Colorado Department of Education Principal License #164806 expires 11/20

Client Rights, Policies, and Important Information:

- You are entitled to receive information about the methods of Psychotherapy/ Assessment, the techniques used, the duration of the therapy (if known), and the fee structure. Please ask at any time and review our financial and procedural policies.
- The information provided by and to a client during therapy is legally confidential except durning the following:

  Confidentiality cannot be maintained when:

  - Client tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat. I must take steps to inform a parent or guardian or police of what the client has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
  - Client tells me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat. In this situation, I'm required to inform the person who is the target of the threatened harm and the police.

    - Client tells me, or I otherwise learn that, it appears that a child, elderly, and/or disabled person is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
    - I am ordered by a court to disclose information.
- There will be times when I will consult with a colleague or another professional such as my supervisor, about issues raised in therapy. Your confidentiality is still protected during consultation by myself and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed.
- I will provide non-emergency psycho-therapeutic services by scheduled appointment only. If I believe the client needs are above my level of competence or outside of my scope of practice, I am legally required to refer, terminate, or consult.
    - If, for any reason, you are unable to contact me 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 after hours treatment from any counseling agency, center, emergency room, hospital or similar facility, you are solely responsible for any fees due.
- Paper Client records are kept in locked file cabinets. Electronic records are stored on the computer. Information is backed-up regularly through additional hard drives and on "the cloud."
- 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.

I have read the preceding information and it has also been provided verbally. I understand my rights as a client or parent of a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. 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 for whom I am requesting psychotherapy/assessment services.

Client('s)Name(s):_____DOB:_____

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

I Have been give access and have read my HIPPA rights: _____ _____