



Alpenglow Counseling & Consultation, PLLC
13611 E. 104th Ave. #800 PMB 40, Commerce City, CO 80022
<https://alpenglowcc.org>
 e. Info@AlpenglowCC.org | p. 303-909-0016

Thank you for your interest in working with us! We are excited for the opportunity to offer you affirming, accessible, trauma-invested, customized mental health and related services. We know that it can be challenging to select a provider and welcome the opportunity to support you as you determine what may be best for you.

DISCLOSURE STATEMENT & POLICIES

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. Alpenglow Counseling and Consultation, PLLC, (herein referred to as “ACC”) is located at 13611 E. 104th Ave. #800 PMB 40, Commerce City, CO 80022. The mental health professionals at ACC are:

Dr. Jillian M. Blueford, LPC

Education: Bachelor of Arts – Psychology; University of Central Florida; 2013
 Master of Arts – Mental Health Counseling; Rollins College; 2016
 Doctor of Philosophy – Counselor Education; University of Tennessee; 2019
Licenses: License Professional Counselor in the State of Colorado, LPC.0016833
 National Certified Counselor: Certification No.884315

Dr. Stacy A. Pinto, LPCC

Education: Bachelor of Arts – Psychology; Marist College; 2007
 Master of Arts – Counseling; Montclair State University; 2010
 Certificate – Advanced Counseling; Montclair State University; 2012
 Doctor of Philosophy – Counselor Education; Montclair State University; 2018
Licenses: Licensed Professional Counselor Candidate in the State of Colorado, LPCC.0018072
 National Certified Counselor: Certification No. 337048
 Certified School Counselor (NJ): Certification No. 615068
Supervisor: Dr. Jillian M. Blueford, LPC

2. Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old. In accordance with best practices, the Mental Health professional will encourage the participation of client’s parents for youth under the age of 15. Additionally, the mental health professional may notify the parent or legal guardian, without the minor’s consent, if in their professional opinion the minor is unable to manage their own care or treatment, or if the minor expresses any suicidal ideation.

In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is ACC’s policy to seek the consent of both parents/legal guardians, however this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination and this is the governing policy unless the child’s health, safety, and welfare could be at risk. If this is the case, you must inform the ACC so that appropriate action for the protection and welfare of the child may be taken. This disclosure statement contains the policies and procedures of ACC and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).





3. The Colorado Department of Regulatory Agencies (“DORA”), Division of Professions and Occupations (“DOPO”) has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and Unlicensed Psychotherapists. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Professional Counselor Examiners regulates Licensed Professional Counselors and Licensed Professional Counselor Candidates and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through ACC’s internal process.
4. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.
5. Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Unlicensed Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination. With the exception of Unlicensed Psychotherapists, all mental health professionals are required to complete continuing education for the duration of their active licenses.

Certified Addiction Technicians must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or equivalent, and complete 1,000 hours of supervised experience. Certified Addiction Specialists must have a bachelor’s degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselors must have a clinical master’s degree, pass the Master Addiction Counselor Exam, and complete 3,000 hours of supervised experience. Licensed Social Workers must hold a master’s 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 Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master’s degree in his or her 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-doctoral supervision. An Unlicensed Psychotherapist is a psychotherapist listed in Colorado’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. Unlicensed Psychotherapists are required to take the jurisprudence exam.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

As a client 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.

1. **Fees:** My fee structure, services, and fee policy are outlined as follows.
 - A. **Services**
 - i. **Individual Counseling Session:** \$200.00 per hour
 - a. Sliding scale available to those who qualify, which *may* reduce the session fee to as low as 25% of the full hourly rate.
 - ii. **Individual Supervision:** \$125
 - a. Sliding scale available to those who qualify, which *may* reduce the session fee to as low as 25% of the full hourly rate.
 - iii. **Group/Triadic supervision:** \$150 per session.
 - iv. **Group and/or Relationship Systems Counseling:**
 - a. 2-4 clients: \$200.00, flat fee
 - b. 5-8 clients, \$240.00 for 5 clients, plus an additional \$40 for each client (8 clients max.)
 - v. **Consultation:** Starting at \$35.00 per 30-minute increments, depending on specific services rendered
 - vi. **Case management:** \$35.00 per 30-minute increments





- B. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a “Credit Card Authorization” form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.
 - C. Therapy fees and treatment are based on a 45-50 minute clinical hour instead of a 60 minute clock hour so that I may review my notes and assessments on your behalf.
 - D. **ACC is not a Medicaid provider.** If you have or obtain Medicaid coverage that includes mental health services, I **am not** able to offer mental health services to you. As a client at ACC, it is your duty to disclosure, regardless of your age, whether you are a Medicaid beneficiary and therefore subject to Medicaid policies and procedures.
 - E. **ACC does not accept insurance.** Our practice is self-pay only and clients will be responsible for the full amount billed for their services.
 - F. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is \$600.00 per hour.
 - G. As a client at ACC, you have the right to receive a “Good Faith Estimate” in writing explaining how much your psychotherapy services will cost. Under federal law, health care providers, including mental health providers, are required to give patients who do not have insurance or who are not using insurance an estimate of the bill for medical items and services. You may request a Good Faith Estimate in advance of an already scheduled psychotherapy session. or at any point during your treatment.
2. **Restrictions on Uses:** You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however ACC is not required to agree to a restriction request. Please review ACC’s Notice of Privacy Policies for more information.
 3. **Second Opinion and Termination:** You are entitled to seek a second opinion from another therapist or terminate therapy at any time.
 4. **Sexual Intimacy:** In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Professional Counselor Examiners.
 5. **Confidentiality**
 - A. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Certified and Licensed Addiction Counselor, or an Unlicensed Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client’s consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.



- B. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-245-220. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S. § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.
- C. Additionally, 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 our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out ACC's Consent for Communication of Protected Health Information by Unsecure Transmissions.
- D. **For clients receiving counseling services from Stacy Pinto:** As a candidate, I am under the supervision of Dr. Jillian M. Blueford, LPC. As such my supervisor will be monitoring the therapy services I provide you. You may be introduced to my supervisor, if we deem it appropriate, and information you share with me may also be shared by me with my supervisor. As part of my supervision, my supervisor may review my case notes, clinical work, and/or request to observe your therapy sessions. Any requests to observe our therapy sessions, whether live or by video/audio recording, will require a separate consent to observe/record our sessions. My supervisor will adhere to all the same policies and procedures in this Disclosure Statement, including all provisions relating to confidentiality. Any disclosure of confidential and protected health information will require you to sign a separate Authorization for Release of Information. By signing this form, you consent to these policies.
6. **Extreme Risk Protection Orders Policy:** According to C.R.S. § 13-14.5-103 a licensed health care professional or mental health professional (as defined in C.R.S. § 13-14.5-102) may file a petition for a temporary extreme risk protection order. Pursuant to article 14.5, an extreme risk protection order may warrant the surrender of firearm(s) when there is a significant risk of causing personal injury to self or others by having custody or control of a firearm(s). If at any time during the course of treatment the need to enact this policy arises, as the mental health professional, I shall make reasonable efforts to limit protected health information to the minimum necessary to accomplish the filing of the petition. The decision of a licensed health care professional or mental health professional to disclose protected health information, when made reasonably and in good faith to comply with this article, shall not be the basis for any civil, administrative, or criminal liability with respect to the licensed health care professional or licensed mental health professional.
7. **“No Secrets” Policy:** When treating a couple, family, or other relationship system, the full system is considered to be the client. At times, it may be necessary to have a private session with an individual member of that system. There may also be times when an individual member of the system chooses to share information in a different manner that does not include other members of the system (e.g., on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless I am required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the full system, it may be necessary to share that information with the other members of the system in order to facilitate the therapeutic process. As your therapist, I will use my sole discretion and best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, I will first give the individual the opportunity to make the disclosure to the other individual(s)



themselves. This “no secrets” policy is intended to allow me to continue to treat the system by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the relationship system being treated. If you believe it to be necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

8. **“No Secrets” in Custody Circumstances Policy:** When treating a Client who is a Minor under the age of twelve (12) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email (i.e., all communication will “cc” both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, I reserve the right, in my sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, I will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or regulations regarding the protection of the health, safety, and welfare of the child/ren.
9. **Extraordinary Events:** In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter “extraordinary event”), the following Mental Health Professional Designee (MHPD) will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the MHPD will contact you. Please let me know if you are not comfortable with the below listed MHPD and we will discuss possible alternatives at this time.

For clients primarily working with Stacy A. Pinto:

NAME: Jillian M. Blueford CREDENTIALS: PhD, LPC, NCC, CT, FT
ADDRESS: 13611 E. 104th Ave. #800 PMB 40, Commerce City, CO 80022
TEL: 970-528-0634

For clients primarily working with Jillian M. Blueford:

NAME: Stacy A. Pinto CREDENTIALS: PhD, LPCC, NCC
ADDRESS: 13611 E. 104th Ave. #800 PMB 40, Commerce City, CO 80022
TEL: 303-909-0016

The purpose of the MHPD is to continue your care and treatment with the least amount of disruption possible. You are not required to use the MHPD for therapy services, but the MHPD can offer you referrals and transfer your client record, if requested.

10. **Maintenance of Client Records:** As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of Professional Counselor Examiners, ACC will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. If the client is a minor, the record shall be retained for a period of seven years commencing either upon the last day of treatment or when the minor reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years. ACC cannot guarantee a copy of your Client Record will exist after this seven-year period.
11. **Electronic Records:** ACC may keep and store client information electronically on ACC’s laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, ACC may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. ACC may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged. ACC may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. ACC uses a cloud-based service for storing or backing up information. The cloud-based backup system ACC uses is SimplePractice and the email service provider ACC uses is Alpenglow email via GoDaddy. ACC may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information ACC has employed the following security measures:



- Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures ACC employs, please ask.

12. **Availability & Response Policy:** My normal business hours are from Monday-Friday, 9:00am-4:00pm. However, the majority of my business hours are devoted to structured, time-limiting responsibilities (e.g., counseling sessions with clients), which means I am typically unavailable for immediate contact via phone, text, or email. **This is especially true for emergencies, as I am not equipped to respond immediately. If you are experiencing an emergency, please call 911.**

The best way to contact me is via email. Every effort will be made to respond to you in a clear and timely manner. Voicemails, text messages, and emails will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. It is my policy to return all phone calls, texts, and emails during my normal business hours (referenced above). I also reserve the right, in my sole discretion, to return communication outside of these hours; but any communication which I initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of my normal business hours.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that ACC may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with ACC's Consent for Communication of Protected Health Information by Unsecure Transmissions.
2. I understand that if I initiate communication via electronic means that I have not specifically consented to in ACC's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.
3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my therapist.
4. I understand that ACC exclusively provides Teletherapy, such as therapy over telephone or video platform. I understand I will be asked to complete an additional consent form, and that I agree to utilize a secure and HIPAA compliant means for communication to ensure confidentiality and the protection of private information.
5. I understand that my therapist, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that ACC has, or may have, a business social media account page. I



understand that there is no requirement that I “like” or “follow” this page. I understand that should I “like” or choose to “follow” ACC’s business social media page that others will see my name associated with “liking” or “following” that page. I understand that this applies to any comments that I post on ACC’s page as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and **not** through social media.

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.
7. I understand my therapist provides non-emergency therapeutic services **by scheduled appointment only**. If, for any reason, I am unable to contact my therapist by the telephone number provided to me and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado’s Crisis Hotline (844) 493-8255. I understand I may also use the National Suicide Prevention Lifeline, 988. ACC does not provide after-hours service without an appointment. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due.** I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will respond in accordance with their availability and response policy, as referenced on page 6.
8. If my therapist believes my therapeutic issues are above her level of competence or outside of her scope of practice, my therapist is legally required to refer, terminate, or consult.
9. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.
10. I understand that if I have any questions about my therapist’s methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to **sign a separate Consent for Third-Party Participation Agreement** or may have to sign a separate disclosure statement in order to participate in therapy.
11. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with ACC or my therapist, my treatment will be considered “terminated.” I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with ACC. Ability to resume therapy after sixty (60) days will depend upon my therapist’s availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand “discontinuing therapy” means that I have not had a session with my therapist for at least sixty (60) days, unless otherwise agreed to in writing.
12. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.
13. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of



counselor to her relatives, friends, the relatives of friends, people known socially, or business contacts.

14. I understand that should I cancel within 48 hours of my appointment or fail to show up for my scheduled appointment without notice (“no-show”), excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.

15. I also affirm, by signing this form, I am at least twelve (12) and consent to treatment and therapy services here at ACC. In the event that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of twelve (12) and for whom I am requesting therapy services here at ACC, I understand it is ACC’s policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren’s treatment in accordance with DORA policy.

If I am the non-custodial parent signing this consent form for my minor child/ren’s treatment in accordance with DORA’s policy, I understand that my access to my child/ren’s treatment and client record may be limited by court order.

16. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with ACC, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. I also understand that it is ACC’s policy to request and seek consent from both my minor child/ren’s parents, but that such consent does not supersede the Court Order Custody Agreement and/or Parenting Plan. By signing this form, I understand and consent to ACC’s “No Secrets” in Custody Circumstances Policy as outlined above. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist’s practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

17. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that ACC is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

Client Name/Signature

DATE

Parent/Legal Guardian Signature (Please specify Relationship to Client)

DATE

Parent/Legal Guardian Signature (Please specify Relationship to Client)

DATE

Provider Signature

DATE

Supervisor’s Signature

DATE

