

DISCLOSURE STATEMENT and HIPPA Form

TRCS, LLC

Renee Storm, MA, LPC, CAC III, CSAT, EMDR

Colorado State law requires that all licensed and unlicensed psychotherapists provide all new clients with a “Disclosure Statement” which must contain information specified by the Psychologist Licensing Board.

MY OFFICES AND CONTACT INFORMATION:

Phone Number Call or Text # 720-281-0495

Email: rs@trc-services.com

Primary Office

14960 Woodcarver Rd Ste. #202

Colorado Springs, CO 80921

Legal Disclosures and Confidentiality:

By law, all therapists in Colorado are required to disclose the following information.

Renee Storm: Credentials & Degrees: Licensed Professional Counselor in the State of Colorado (License #LPC.0014459) and Certified Addiction Counselor in State of Colorado (Level III) (Cert. #ACC.000207812) ; M.A. in Mental Health Counseling, Regis University, Denver, CO; Bachelor of Science in Human Services, University of Phoenix, Co Campus, A.A. in Chemical Dependency Counseling, Colby Community College, Colby, KS.

• The information provided by clients during therapy sessions is legally confidential, except as provided in section 12-43-218 of the Colorado Mental Health Statute, as follows:

- If I suspect child abuse or neglect, I must report it to the Department of Human Services
- If I believe you are a danger to yourself or are gravely disabled
- If I believe you are a danger to others.
- If I am ordered by a judge to release information.
- If you or your heirs, executors or administrators file suit or complaint against me regarding therapy.
- If you give written permission for Release of Information (ROI) to another professional or designated individual.

In the event of any of these situations, I would attempt to discuss my intentions with you before any action is taken, and I would limit disclosure of confidential information to the minimum amount necessary.

• The practice of psychotherapy in Colorado is regulated by the **Department of Regulatory Agencies**. **If you should have a complaint about unethical conduct, you may contact the Grievance Board:** Department of Regulatory Agencies, Colorado Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202. Phone: 303-894-7766.

• In a professional relationship, sexual intimacy is never appropriate and should be reported to the board.

The counseling relationship: We will be discussing personal concerns or aspects of your life you would like to look at closer. You are entitled to receive information from me about my methods of counseling, techniques used and the duration of counseling. You may also seek a second opinion if you wish to do so. It is understood that no guarantees have been made to me as to the success of treatment and our counseling relationship can be terminated at any time.

Professional Consultation. It is an important standard in the field of psychotherapy to consult with other professionals regarding certain cases to improve the overall quality of care given. I may consult with another professional without revealing your identity or related identifying information in order to increase my level of awareness about important dynamics in the work I is doing. Please let me know if you have further questions regarding this matter.

Contact outside of session: If you need to contact me outside of session the best method to do so is via text message to #720-281-0495. You may also leave a phone message, but my return time will not be as prompt. Please limit texting, email, and phone messages for conversations pertaining only to scheduling or rescheduling appointments.

Email and Online Social Networking Policy: Because it is not possible to guarantee the confidentiality of email communications, please use discretion in deciding whether to communicate with me via email. I cannot be held responsible for any information lost in transit or viewed by a third party. Email should only be used for brief, general questions. Email: rs@trc-services.com

Emergencies: Due to the nature of my work I am rarely available outside of session. If you need to talk to someone immediately, please call 911 or the 24-hour National Crisis Hotline at 1-800-273-TALK, or go to your nearest hospital emergency room.

Payment and Fees: My standard fee for mental health therapy is individualized. Please refer to your provided “Financial Agreement and Payment” Form. Payment is due at each session, unless other arrangements have been made. Fees for additional time or services will be pro-rated at my regular fee. Such additional services may include, but are not limited to, consultation with other professionals, preparation of reports or correspondence, and phone calls lasting over 10 minutes. Acceptable forms of payment are cash and check. If your check is deposited with insufficient funds, you will be charged an additional \$35 to cover bank fees.

Late Cancellation: My practice is at 100% full capacity, along with a waiting list. Therefore, if you are in need of cancelling your session it will need to be done no more than 24 hours before your set time. This allows me time to schedule someone else in your spot. If enough notice is not given then you will subject to a no-show fee. Exceptions are made in circumstances such as unexpected illness, family emergencies, and weather related issues.

Insurance: Although I do not bill insurance companies directly, at your request I will provide you with a statement of services that you can then submit to your insurance company for reimbursement. Please be aware that submitting an invoice for reimbursement carries a certain amount of risk, as I cannot control how your information is used once submitted. Not all therapeutic issues are reimbursable; it is your responsibility to verify the specifics of your coverage.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a sensitive and confidential nature, it is agreed that should you be involved in legal proceedings, neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

My signature below affirms my informed and voluntary consent to enter therapy. I understand the office policies and procedures, as well as my rights as a client. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment at any time.

Client Signature

Date

Therapist Signature

Date

Parent/Guardian Signature (if client is a minor)

Date