Statement of Disclosure, Confidentiality, and Informed Consent

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Credentials, Degrees, and Licensure:

Bachelor of Arts in Psychology, Philosophy, Women's Studies, Cultural Anthropology, Evergreen State College, Olympia, WA | 2000

Master of Arts in Clinical Psychology, Integrative Emphasis, California School of Professional Psychology at Alliant International University, San Diego, CA | 2008

Doctor of Psychology in Clinical Psychology, Integrative Emphasis, California School of Professional Psychology at Alliant International University, San Diego, CA | 2012

Unlicensed Psychotherapist, NLC.0110917, State of Colorado Department of Regulatory Agencies | 2020

Client Rights, Important Information and Practice Policies:

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. 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. This would result in the termination of therapy. Sexual Intimacy: In a professional relationship, sexual intimacy is never appropriate and should be reported. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section at (303) 894-7800 or DORA_MentalHealthBoard@state.co.us

Confidentiality:

The information provided by and to a client during therapy is legally confidential with some exceptions. The therapist cannot be forced to disclose 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. There are exceptions to this confidentiality including: You sign a release of information form (ROI), giving permission for the therapist to provide specified information about your treatment to a particular individual or agency. The therapist reasonably suspects or has proof of child abuse and/or neglect. The therapist reasonably suspects or has proof of abuse, neglect, and/or exploitation of elderly or disabled individuals. You are in imminent danger of harming yourself and/or others, including those identifiable by their association with a specific location or entity. In this situation, your primary therapist is required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened. Therapist testimony is subpoenaed in criminal court cases and orders to violate privilege by judges in child-custody, divorce, and other court cases. There may be additional exceptions as provided by HIPAA regulations and other federal and/or Colorado laws and, regulations such as those listed in C.R.S 12-43- 218 that may apply. Your therapist will identify these situations, if feasible, as they may arise during treatment or during the professional relationship. 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. There is a risk that the electronic or telephone communications may be compromised, unsecured, and/ or accessed by a third-party. Please limit communication by text or email to administrative/scheduling purposes only and do not use them as an avenue for therapy. NEVER use email or text for emergencies. You have the right to choose what methods of contact you would like to receive. There may be times when I may need to consult with a colleague or another professional such as an attorney or supervisor, about issues raised by you in therapy. Your confidentiality is still protected during consultation by me and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives your primary therapist permission to consult as needed to provide professional services to you as a client. No Secrets Policy: When treating a couple or a family, the couple or family is considered to be the client. At times, an individual member of the couple or family chooses to share information privately; in the event that information is disclosed that is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. This “no secrets” policy is intended to allow your therapist to continue to treat the couple or family 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 couple, or the family being treated.

Emergency/ Crisis Needs:

I provide non-emergency psycho-therapeutic services by scheduled appointment only. As such, I may not answer emails or phone calls after hours (working hours are from 9-3 daily) or on the weekends. You, as a client, understand that if you leave a voicemail or email for me, I will return it within 24-48 hours, excluding holidays and weekends. As I provide services in an outpatient practice, I do not provide emergency psychotherapeutic services or transportation to/from the hospital. If, for any reason, you, as a client are unable to directly contact your therapist by the telephone number provided, and you are having a true mental health (or physical) emergency, *please dial 911, go to your nearest emergency room, or call Colorado’s Crisis Hotline (844) 493-8255.* You can also seek crisis counseling and support through Mental Health Partners Boulder Walk in Clinic at 303-447-1665 or in person at 3180 Airport Road Boulder, CO, 80304. 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.

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 Licensed Professional Counselor Examiners, contact information, reasons for therapy, notes, etc. for a period of seven (7) years after the termination of therapy. I will maintain your client record (consisting of disclosure statement) or the date of our last contact, whichever is later. I cannot guarantee a copy of your Client Record will exist after this seven-year period. Paper Records: Paper patient records are kept in locked file cabinets at my office, behind a locked office door and a locked building door. Electronic Records: I may keep and store client information electronically on local laptop or desktop computers, and/or some mobile devices. To maintain security and protect this information, the following may be used: firewalls, antivirus software, changing passwords regularly, remotely wiping information if device is lost or stolen, and encryption methods to protect computers and/or mobile devices from unauthorized access. A cloud-based service/ EMR service

for storing or backing up information with HIPPA obligations to protect data, and an email service (Google business) may be used. Social Media: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends or contacts can compromise your confidentiality, respective privacy, and professional boundaries. You, as a client understand that I have a business social media account page. You understand that there is no requirement that you “like” or “follow” this page. Should you choose to “like” or “follow” me on my social media page, please note others will see your name associated with “liking” or “following” that page. This applies to any comments that you post on this business page/wall as well.

Therapeutic Results:

Therapy is a unique journey that can lead to awareness, health, and healing. However, there are no guarantees 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. Therapy is a collaborative effort and requires a personal commitment from the client. The therapist's role in this journey is not to “fix” but to facilitate each client’s personal journey towards health.

Financial Agreement and Cancellation Policy:

If you need to cancel a scheduled appointment, please provide notice at least 24 hours in advance via email or phone. If canceled less than 24 hours in advance or no-showed, you may be subject to pay a cancellation fee equal to the cost of the session fee. Payment is required at time of service. By signing below, you acknowledge you are responsible for all balances due. If using insurance and you are denied for any reason, you are responsible for the payment of services. Additionally, unpaid balances over 120 days may be sent to a collection agency.

Agreement:

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 Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice of Privacy Practices or declined a copy at this time. I understand that I may request a copy of the Notice of Privacy Practices at any time. If you have questions or would like more information, please ask at any time. I have read the preceding information and it has also been provided verbally if I am unable to read or have no written language.

Client’s Name (Please Print):

Client or Client’s Responsible Party’s Signature:

Date signed:

(IF) signed by Responsible Party, please print name and state relationship to client and authority to consent: