DISCLOSURE STATEMENT/CLIENT RIGHTS

1. Therapist: Mindy Berry, MA, LPCC
Address: 19751 Mainstreet, suite 395 , Parker, CO , 80138, (720) 924-1117

2. Education: **Masters Degree in Clinical Mental Health**
Adams State University, Alamosa, Colorado
Mindy is a Licensed Professional Counselor Candidate (LPCC) in the state of Colorado License # LPCC.0016771

Mindy's training, teaching, and clinical experience aligns with an Integrative therapeutic approach (Cognitive Behavioral Therapy, Person-centered, and many other theories).

ABOUT MY CLIENT RIGHTS:

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 Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.

The Office of Behavioral Health is responsible for regulating the provision of behavioral health services by developing and monitoring reasonable and proper standards, rules, and regulations. They are located at: 3824 W Princeton Cir, Denver, CO 80236 and their telephone number is: (303) 866-7400.

House Bill 17-1011 has been signed into law by the Colorado Governor. This new law establishes a statute of limitations for filing complaints with the licensing boards regarding the maintenance of records.
Any person who alleges that a mental health professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably

should have discovered this. Pursuant to law, my practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.
When the client is a child, the records will be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

4. CLIENT RIGHTS AND IMPORTANT INFORMATION

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. 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 Board that licenses, certifies or registers the therapist.

d. Generally speaking, 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 **elder abuse or neglect and 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;
- **(5) I am required by HB 14-1271 to report any threats against locations such as churches, schools, theatres, workplaces, etc to law enforcement**, and
- (6) I may be required by Court Order to disclose treatment information.
- (7) I understand that my therapist cannot guarantee confidentiality when using tools of technology for scheduling/therapeutic services, such as phone, e-mail, text messaging, skype, etc.

e. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.

f. 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.

g. The use of recording devices is strictly prohibited without client/therapist written consent. Neother the client or therapist can audio record or video record the session unless agreed upon beforehand in writing.

h. I understand my therapist provides non-emergency therapeutic services by scheduled appointment. Should a crisis arise, I take the responsibility to notify proper authorities, call 911, or take myself to an emergency room for immediate support. I understand that if my therapeutic issues are above the level of training or competency of my therapist, she is legally required to refer, terminate, or consult.

i. **Couples Waiver -** I understand that in the course of couples and family work it is sometimes helpful to remind clients of work done in individual sessions in joint sessions. I give permission for my counselor to use her discretion in discussing confidential information from my individual sessions with me and my partner/family as a couple/family. I understand my counselor does not hold "secrets" in therapy or keep information from partners that may hinder therapeutic progress/treatment.

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.

6a. **Client Rights disclosure and use of drug abuse patient records (CFR 42 Part 2)**

(a) *Disclosure authorization*

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) *Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent*

(1) The content of any record referred to in subsection (a) of this section may be disclosed in

accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

Report Violations:
Pursuant to 42 CFR 2.5, if you believe I have violated your privacy rights, you have the right to contact the United States Attorney's Office for the District of Colorado to report any suspected violation. Their office is located at 1801 California Street, Suite 1600, Denver, CO 80202, and they can be reached via telephone at (303) 454-0100.

7. My normal fee is **$90.00 per session** and payment is due at the time of session.. Psychotherapy is provided for 45 to 50 minute clinical hour with the last 5 minutes being used for scheduling. Therapists offers 90 minute sessions if requested and therapeutically necessary.

7a. **No-Shows and Cancellation Fees**: All appointments must be cancelled 24 hours prior to scheduled appointment time to avoid charges for a "no-show" or "late-cancellation." After-hour messages regarding cancellations may be left on the Mindy Berry Counseling phone line (720) 924-1117. You agree to be charged $50.00 for a first time No-show or late-cancellation appointment subsequent No-show or late-cancellation appointment will be charged the full session fee. Insurance will not pay charges for "no-shows" or "late cancellations." Payments are to be made via cash/check or credit card, and a penalty fee

of $45 will be assessed on all checks returned by the bank for any reason. Additional credit card processing fee will be applied to charge.

AS A PSYCHOTHERAPY CLIENT I UNDERSTAND THAT:

9. By agreeing to receive services from me, you agree not to subpoena me to testify or produce records in court in any type of litigation. You also agree not to ask me to write any reports for the court or for your attorney.

If you should request treatment records from me, I may provide you with a treatment summary in compliance with Colorado law.

10. I understand that there may be times when my psychotherapist may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my psychotherapist and the professional consulted.

11. I understand my psychotherapist provides non-emergency psychotherapeutic services by scheduled appointment. If my psychotherapist believes my psychotherapeutic issues are above his or her level of competence, or outside of his or her scope of practice, he is legally required to refer, terminate, or consult. **If, for any reason, I am unable to contact my psychotherapist by telephone, (720) 924-1117, and I am having a true emergency, I will call 911 or check myself into the nearest hospital emergency room.**

Initial ________________

12. I understand that I have any questions or would like additional information, I may please feel free to ask during the initial session and any time during the psychotherapy 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 psychotherapy when deemed necessary by myself or my psychotherapist

14. I understand that I am legally responsible for payment for my psychotherapy

services, <u>if, for any reason</u>, my insurance company, HMO, third-party payor, etc. does not compensate my therapist. I also understand that signing this form gives permission to my psychotherapist to communicate with my insurance company, HMO, third-party payor, biller, or anyone connected to my psychotherapy funding source.

15. <u>CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT</u>

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my therapist to seek consultation with other psychotherapists or professionals as the need arises, and communicate with any attorneys, CFIs, officers of the court, judges, or other professionals related to my court case. I also consent to, if I use the clinic, for me, my minor child, and/or any of my minor children to be observed and/or videotaped during psychotherapy by staff, students, and/or treatment team members. 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 that I am requesting psychotherapy services from Mindy Berry MA, Licensed Professional Counselor Candidate. In accordance with HIPAA, this consent to treatment expires at termination of treatment, or twelve months after last session. This consent form can be revoked at any time by submitting written request.

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Client Signature Date

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Therapist Date