WILLOW THERAPY

Candice Berger

509 Scott Ave 2B
Woodland Park, CO 80863

2210 E La Salle St #221
Colorado Springs, CO 80909

719-201-8714

Willowtherapy@yahoo.com

Disclosure Statement

This statement is being provided to you so that you are aware of your rights as a psychotherapy client. Please read this and discuss any questions or concerns you have before signing it.

I am Licensed Professional Counselor # LPC.0014523, National Certified Counselor, certificate # 682810, and an Associate Provider for SOMB. I have a Master's Degree in Counseling from Regis University.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, license school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy. All questions and /or complaints should be addressed to the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7766.

Clients rights and important information:

The information that you share in psychotherapy, including substance use (42 C.F.R. Part 2) is confidential and protected by law; therefore, you hold a legal right to refuse the release of protected information and this information may not be disclosed to anyone without your written consent. There are specific circumstances or exceptions to your rights of confidentiality whereby professionals BY LAW MUST REPORT otherwise confidential information. These exceptions are referred to as "*limits of confidentiality*" and are defined by law under Colorado Statute (C.R.S. 12-43-218):

1. If you have any ***intention to harm yourself*** necessary steps will be taken to prevent self-harm from occurring.
2. If you ***threaten significant bodily harm or death to another person*** there is a LEGAL DUTY TO WARN and reasonable care will be taken to protect the intended victim and to prevent the harmful actions from occurring. This includes but is not limited to directly informing the intended victim and/or appropriate legal authorities.
3. If you share information that conveys reasonable suspicion that ***you, another child, or member of a protected vulnerable population may have been abused or neglected*** this information will be reported to the Department of Social Services and/or to legal authorities. This includes any case of physical abuse, exploitation of a child, neglect, or sexual abuse. Any disclosure of sexual abuse of a child will be reported to legal authorities.

4. Any information specifically requested by the court through a legally binding ***court order*** will be provided.
5. If you **express a significant threat against a school or the occupants** of a school, or if you **show behavior that express a significant threat to the health and safety of students, teachers, administrators, or other school personal** information will be reported to legal authorities.

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), a copy of the code of ethics that governs your therapists' practice and my fee structure. Please ask if you would like to receive this information.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that license, registers, or certifies, registrant, or certificate holder.

At any time you may seek a second opinion from another counselor, and you may terminate the counseling at any time.

Fee Information:

My standard fee is $80 for a 50-minute individual session, or reimbursement amount from accepted insurances and agenciencies and any related co-pay. I request payment by check or cash at the time service is rendered. If checks are returned due to insufficient funds, a $25 fee will be charged to you. As a general policy, I request that clients pay me directly. Meetings with auxiliary medical either by phone or in person and report writing will be billed at my standard fee. I do not provide legal consultations outside of court orders. If payment is in arrears more than 90 days and a fee payment schedule cannot be agreed upon, your account will be turned over to a collections agency, an attorney, or small claims court.

Missed appointments and cancellations:

If you are unable to keep you appointment, please notify me as soon as possible. **If you cancel or miss an appointment without giving me 24 hours' notice, you subject to being billed for the full fee for the session.** If you are late for an appointment you will be charged for an entire session.

Telephone calls:
If you need to speak with me between regularly scheduled sessions, please leave a message and I will return your call as soon as possible. Telephone calls for the purpose of scheduling are expected and are not billed. I do not charge for brief conversations but any discussion that goes beyond 10 minutes or more than three 10 minute discussions per week will be billed to you on a prorated basis.

Emergencies:

Please be aware that I provide non-emergency face-to-face services by scheduled appointment. As a solo practitioner in an independent practice, I am unable to provide extensive or ongoing emergency care. If you believe that you will need frequent emergency attention between scheduled sessions, please discuss this with me immediately so that I can refer you to a provider who can better serve your needs. If I

believe your psychotherapeutic issues are outside my scope of practice, I am legally required to consult, refer or terminate treatment.

If you are experiencing an emergency situation, please call 911, or proceed to the nearest hospital emergency room.

Due to conflicts of interests I am not able to provide services to individuals who are currently involved with the Division of Youth Services. If at any time you become involved with the Division of Youth Corrections I will need to be notified and it will be determined if I am required to terminate services and provide you with references for another therapist.

Health Information Privacy Notice (HIPPA):

By signing this disclosure you acknowledge receipt of the HIPPA policies for your review. Once you have reviewed the policies, please return a signed copy to me. **You are not required to sign this notice to receive treatment.** Please verbally inform me if you elect to not sign the notice.

If you have any questions or would like additional information, please feel free to ask me.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client/ patient.

_____ _____

Client/ Patient Signature Date

_____ _____

Parent/ Guardian Signature Date

_____ _____

Candice K. Berger, LPC Date