

### **Informed Consent for Treatment and Disclosure Statement**

Welcome! It is my desire to assist you in making informed decisions about your treatment. As a client of psychotherapy and as a consumer, you have certain rights. Therefore, I will explain the information you are entitled to know, such as my view of the therapeutic process, and my expectations for the cooperative working agreement. Please feel free to ask any of the following information.

- Graduated from University of Northern Colorado with a Masters of Art in Agency Counseling/Family Therapy in December, 1989.
- Graduated from University of Maryland with a Bachelor's Degree in Therapeutic Recreation in December, 1986.
- Everyone fifteen or older must sign a disclosure statement. This disclosure statement contains the policies and procedures for receiving psychotherapy services. No medical or psychotherapeutic information, or any other information related to your privacy will be revealed without your permission unless mandated by Colorado law.
- You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing at any time during psychotherapy.

### **About My Client Rights**

The Colorado Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapist, certified school psychologist, and unlicensed individuals who practice psychotherapy. The agency within DORA that has responsibility specifically is the Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202, 303. 894.7800.

- You are entitled to receive information from me about my methods of therapy, the techniques applied, the duration of therapy (if it can be determined), and the fee structure. Please ask if you would like to receive this information
- You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship (such as psychotherapy), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at 303.894.7800.
- Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and cannot be disclosed without our written consent.

There are legal exceptions to the general rule of legal confidentiality. These legal exceptions include:

- Intent to harm others or yourself
- Abuse or suspected abuse of children, and possibly the abuse of elderly or others unable to care for themselves, and or neglect or suspected neglect of children.
- Subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child custody, divorce, and other court cases.
- Also, be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding.
- There are other exceptions, such as threats to national security under the federal Patriot Act, which will be identified to you as the situations arise during therapy.

## The Therapeutic Process

Counseling has both benefits and risks. Benefits for people who undertake counseling often include a reduction in feelings of distress, more satisfying relationships, increased clarity and resolution of specific problems. Growth nearly always brings change, and sometimes change (even positive change) causes stress. Potential risks of counseling involve recalling unpleasant aspects of your personal history that may bring up distressing thoughts and feelings. Every effort will be made to assist you to reach your therapeutic goals. If you have any concerns about your progress or the results of your counseling experience, please talk with me at any time during our work together.

## General Structure of Therapy Sessions

I do psychotherapy in weekly or biweekly sessions of 60 to 90 minute periods. Length or frequency of sessions can be increased or decreased to reflect your therapy needs. It should be noted that if you late for a session, you are still responsible for the total fee of the session and time will still end as usual.

Client Initials \_\_\_\_\_

## Canceling Information and Scheduling

You must call or cancel a session equal to and/or no less than 24 hours in advance or you will be charged the full fee. Certain circumstances may be taken under consideration if this should happen. Appointments can be made either by phone, face to face or by email.

Client Initials \_\_\_\_\_

## Payment

My fee is based on a sliding scale fee. The sliding scale fee range for individual sessions is \$50.00 - \$75.00 for a 60 minute session. Fees for a 90 minute session will range from \$80.00 - \$150.00. Couples session for 60 minutes is \$85.00. Fees for a 90 minute couples session is \$140.00. Family session fees for 60 minutes is \$95.00. A 90 minute family session fee is \$145.00. Sessions can be increased or decreased as needed, wherein the cost would appropriately reflect this change. Payment is due by cash, check or credit card before the service is provided. If there is a returned check, a \$30.00 fee will be applied to the total amount. I have read and understand payment as it applies.

Client Initials \_\_\_\_\_

## Messages

Every effort will be made to return calls and/or emails within 24 - hour period, unless otherwise stated. I will attempt to check my messages during my days off but no guarantee will be made to call you within the 24 hours. I will however contact you on my next business day.

## Emergencies

While my practice is not prepared to handle emergencies, please either dial 911 or head to your nearest Emergency Room. Once you have either called 911 or gone to the Emergency Room, please leave me a voice message indicating you have done so. When signing you understand your psychotherapist provides non-emergency psychotherapeutic services by scheduled appointment. If my psychotherapist believe my psychotherapeutic issues are above her level of competence, or outside her scope of practice, she is legally required to refer, terminate, or consult. If for any reason you are unable to reach your psychotherapist by telephone and you are having a true emergency, you will call 911 or check yourself into the nearest hospital Emergency Room.

Client Initials \_\_\_\_\_

## Other Important Information

I understand that court testimony on my/our behalf is charged at a higher rate including testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time and court room waiting time. Signing this disclosure statement gives permission for my psychotherapist to release confidential information in courtroom testimony and written reports to the Court.

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. By signing this disclosure statement gives my psychotherapist permission to consult as needed to provide professional services to me as a client.

I understand that I have 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. They will also have to sign separate disclosure statements.

This private practice does not take insurance. I understand that I am legally responsible for payment for my psychotherapy services, if, for any reason, a third party payer does not compensate my therapist. I also understand that signing this form gives permission to my psychotherapist to communicate to a third-party payer or anyone connected to my psychotherapy funding source. Failure to pay will be cause for termination of psychotherapy services.

As a client you may choose over the phone counseling as an option. I realize that no phone line is absolutely secure; therefore this psychotherapist, Nancy Bortz is not responsible if information is heard through another cell phone pick up. When receiving phone counseling this therapist cannot assure 100% confidentiality because nothing is certain using technology.

As a client I also understand that text, email, voicemail and phone are not secure lines of communication. Nancy Bortz will not be held liable for miscommunication, or any breach in confidentiality.

### **Client Signature, Acknowledgement, Agreement, Consent**

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 psychotherapist to seek consultation from professional sources if the need arises. By initialing all the above sections you are saying that you read and understand each section listed above.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Psychotherapist Signature** \_\_\_\_\_ **Date** \_\_\_\_\_