DISCLOSURE STATEMENT

1. Megan A. Silberhorn (therapist), Masters Level Clinical Counseling Intern in the State of Colorado, **telehealth only** (see Telehealth Agreement). Appointments are made via All Inclusive Counseling, Inc. (AIC), 203 N 6th St, Rm A, Douglas, WY 82633, (307) 242-1472, jordyn.serfoss.aic@gmail.com. Therapist direct communication (970) 305-5886 (call or text) and megan.silberhorn.aic@gmail.com.

2. Therapist is an unlicensed therapist obtaining a master's degree in clinical mental health counseling at Colorado Christian University, Lakewood, CO. Estimated graduation date is January 2024. Therapist holds a Bachelor of Science in Psychology (2020) from Colorado Christian University, Lakewood, CO. Therapist has nine months of in person counseling experience in a University setting. Therapist is supervised by Leilani Cullen, M.A., LMFT (Supervisor), at All Inclusive Counseling. AAMFT Approved Supervisor. LMFT Colorado #913, MFT Hawaii #240, LMFT Wyoming #254. 2020 N Academy Blvd Ste 261 1919, Colorado Springs, CO, 80909-1567. Any questions or concerns about therapist or therapist practices can be directed to supervisor at: 307-242-1472 or leilaniraycullen@gmail.com.

3. The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies, 1560 Broadway, Ste 1350, Denver, CO 80202, (303) 894-7766.

4. **CLIENT RIGHTS AND IMPORTANT INFORMATION**

a. You are entitled to receive information from therapist about your therapy methods, techniques used, duration (if known), and fee structure.

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 is never appropriate and should be reported to the Board that licenses, registers, or certifies the licensee, registrant or certificate holder.

d. **The maintenance of confidentiality of all written or verbal communications between client and therapist.** The information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed in session is privileged communication and cannot be disclosed. Therapist is committed to keeping the information you disclose confidential. Therapist will not share any information you share with except as provided in C.R.S. 12-43-218.

Below are some examples of exceptions to confidentiality:

1. If you reveal information concerning neglect, physical or sexual abuse of a child or elder, Therapist is required by law to report this knowledge to the appropriate authorities;
2. If you are in danger of causing immediate harm to yourself or others, Therapist is required by law to report this knowledge to the appropriate authorities;
3. If you give Therapist written permission to share information to individuals or institutions as specified by you;
4. In some cases, if therapist is required by a court of law or subpoena;
5. In the case of consultation with another professional counselor, with your consent, for the purposes of professional growth. In this case, your name will not be used.

If a legal exception arises during therapy, if feasible, you will be informed accordingly.

e. When I am concerned about your safety, you consent to 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.

f. If parents request treatment information from me, I may provide a treatment summary, in compliance with HIPAA Standards.

g. To not have sessions or a conversation with me recorded by you, members, or therapist without our advance written signed consent permitting it.

h. To develop your goals and Treatment Plan and learn of the benefits and risks associated with the particular approach, and anticipated frequency, with no absolute guarantee of your desired results by your therapist as it is hard to predict the outcome of therapy.
i. To phone call therapist for any non-emergency reason during office hours: 9:00 a.m. to 5:00 pm. Messages will be returned by the end of the next business day. Therapist is not available on an emergency basis.
j. To text or email for scheduling purposes only. To protect your privileged and private confidential information by not texting or emailing it; it becomes a part of your legal medical record documented and archived in your chart. Emails are retained in the logs of your and my Internet service providers and available to be read by their system administrator(s). All of technology is not confidential and can be hacked into. To consent to sending and accepting texts you recognize the risk that information could be exposed to others when it appears on your phone. Fax is used to transmit and receive health information to and from requested parties with consent. I understand that AIC may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me.
k. AIC may keep and store client information electronically on AIC's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, AIC may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. AIC may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged. AIC may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. AIC uses a cloud-based service for storing or backing up information, Microsoft One Drive and Simple Practice EHR. AIC may maintain the security of the electronically stored information through encryption and passwords.
l. To leave your cell phone in your car to protect privacy in case of spyware vulnerabilities. To turn off GPS tracking on your device if you use location-based services on your mobile phone.
m. To know I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc) to avoid compromising confidentiality and to keep the boundaries of our therapeutic relationship so do not contact me these ways. I understand that AIC has a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" AIC's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on AIC's page/wall as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and not through social media. Know my listings on any site like square, yelp, etc. are not requests to add a review, testimonial, rating or endorsement.
n. To express yourself on any site you wish using a pseudonym not linked to your email address or friend networks to protect your confidentiality, but I cannot respond to any review due to confidentiality, and I may never see them. To communicate anything about therapy or therapist directly in session, even if you decide we are not a good fit.
o. To call 911 or go to the nearest hospital emergency room in the event of a crisis/emergency and seek immediate medical or psychiatric attention. If currently considering or threatening suicide or any form of harm to myself or others, client takes full responsibility for seeking appropriate local help immediately and for any action client may take. Client acknowledges the following resources: www.hopeline.com

1-800-273-TALK(8255) 24hour Suicide Prevention Lifeline	1-800-SUICIDE	1-800-656-HOPE	1-800-TLC-TEEN
Crisis Text Line 741-741 free 24/7 for suicidal thoughts, bullying, depression & other tough issues			

p. To understand that, in keeping with generally accepted standards of practice, therapist may confidentially consult with or receive mentoring from other mental health professionals, i.e. regarding case management. The purpose of the consultation is to assure quality care, and every effort is made to protect the identity of clients. You will be notified as to whom and when requested given a release form to sign prior to the consulting.
q. A proceeding for discipline of a licensee, registrant, or certificate holder may be added to existing statutes; commenced when the board that licenses, registers, or certifies the licensee, registrant, or certificate holder has reasonable grounds to believe that the licensee, registrant, or certificate holder under the board's jurisdiction has committed any act or failed to act.
r. If an adult client requests a copy of the file then my policy is to provide a treatment summary. In the rare case that SSA or a disability agency requests a copy with a specific release for the actual record then the entire copy of the file may be released.
s. If a couple/family client needs individual therapy then individual(s) will be referred. Otherwise couple/family therapy would need to be terminated and couple/family therapy could not resume, and must have written consent of all parties. The risk is one party could subpoena therapist later while treating one and giving information on the couple/family causing complications. Couple/family clients may have individual break-out sessions to support the goals of the couple/family, for intake and assessment. During break-out sessions with one member of the couple/family, we limit confidentiality, meaning anything that's shared in break-out sessions may be shared with the other member(s) to effectively treat the couple/family, with consent. With consent I will use my best judgment as to whether, when, and to what extent first the disclosing member be given the opportunity to share it or I make disclosure to the couple/family, if appropriate. Such information becomes part of the couple/family client's file, and may indicate need to terminate couples/family therapy if shared information indicates continuing couples/family therapy could cause harm, i.e. ongoing affair or characterological domestic violence. As long as no major extreme conflict exists between siblings, they may both receive services here. If you feel it necessary to talk about matters you absolutely don't want to be shared with anyone then consult with an individual therapist who can treat you individually. This prevents a conflict of interest of an individual and a couple/family. Information gained in break-out sessions may be relevant or essential to proper treatment of couple/family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the couple during therapy I might be placed in a situation where I will have to terminate couples/family therapy. This policy intends to prevent such need for termination. A request for records by anyone in couples/family therapy requires the signed authorization of all privilege holders. Information shared by a collateral is not confidential and may be shared if subpoenaed to testify.
t. I will adhere to the Code of Ethics of the American Counseling Association.

5. **METHODS AND TECHNIQUES**

You are entitled to receive information from therapist about methods of therapy and the techniques used. Therapist currently utilizes Person-Centered Therapy as a primary method, incorporating mindfulness and somatic techniques. Issues of special interest are anxiety, depression, women's issues, adjustment disorders, and phase of life issues. Duration is determined by need and measured progress.

6. **NOTICE OF PRIVACY PRACTICES RECEIPT & ACKNOWLEDGMENT OF NOTICE**

You have been offered a copy of Therapist's "Notice of Privacy Practices" to read and it is available on our website. If you have any questions regarding the Notice or your privacy rights, you may inform Therapist.

□ Client Refuses to Acknowledge Receipt

7. **SLIDING SCALE FEE WITH PROMPT PAY DISCOUNT AT TIME OF SERVICE**

Rates increase 5% each year on January 1st.

Standard Rate/100%pay/0%discount applied		10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	100%
90785 Interactive Complex Add on	31	27.90	24.80	21.70	18.60	15.50	12.40	9.30	6.20	3.10	0.00	0.00
90791 Initial Dx Assessment	184	165.60	147.20	128.80	110.4	92	73.60	55.20	36.8	18.40	0.00	0.00
90832 16-37 min Session	93	83.70	74.40	65.10	55.80	46.50	37.20	27.90	18.60	9.30	0.00	0.00
90834 38-52 min Session	147	132.30	117.60	102.90	88.10	73.50	58.80	44.10	29.40	14.70	0.00	0.00
90837 53+ min Session	154	138.60	123.20	107.80	92.40	77.00	61.60	46.20	30.80	15.40	0.00	0.00
90846 Family w/o Client 26+ min	142	127.80	113.60	99.40	85.20	71.00	56.80	42.60	28.40	14.20	0.00	0.00
90847 Family with Client 26+min	184	165.60	147.20	128.80	110.40	92	73.60	55.20	36.80	18.40	0.00	0.00
90839 Crisis 30-74 min	205	184.50	164.00	143.50	123.00	102.50	82.00	61.50	41.00	20.50	0.00	0.00
90840 Crisis Add'l 75+30 min	99	89.10	79.20	69.30	59.40	49.50	39.60	29.70	19.80	9.90	0.00	0.00
90853 Group 45 min(30minKids)	54	48.60	43.20	37.80	32.40	27.00	21.60	16.20	10.80	5.40	0.00	0.00
99404 EAP Preventive	129	116.10	103.20	90.30	77.40	64.50	51.60	38.70	25.50	12.90	0.00	0.00
H0001 Substance Use Screening	120	108.00	96.00	84.00	72.00	60.00	48.00	36.00	24.00	12.00	0.00	0.00
H0004 Substance Use Treatment	38	34.20	30.40	26.60	22.80	19.00	15.20	11.40	7.60	3.80	0.00	0.00
Nominal fee if able to pay											$5-$20	$0-$5
Poverty Level	**>200%**	**200%**	190%	180%	170%	160%	**150%**	140%	130%	120%	110%	100%
Family Size 1	12,761	12,760	12,122	11,484	10,846	10,208	9,570	8,932	8,294	7,656	7,018	6,380
2	17,241	17,240	16,378	15,516	14,654	13,792	12,930	12,068	11,206	10,344	9,482	8,620
3	21,721	21,720	20,634	19,548	18,462	17,376	16,290	15,204	14,118	13,032	11,946	10,860
4	26,201	26,200	24,890	23,580	22,270	20,960	19,650	18,340	17,030	15,720	14,410	13,100
5	30,681	30,680	29,146	27,612	26,078	24,544	23,010	21,476	19,942	18,408	16,874	15,340
6	35,161	35,160	33,402	31,644	29,886	28,128	26,370	24,612	22,854	21,096	19,338	17,580
7	39,641	39,640	37,658	35,676	33,694	31,712	29,730	27,748	25,766	23,784	21,802	19,820
8	44,121	44,120	41,914	39,708	37,502	35,296	33,090	30,884	28,678	26,472	24,266	22,060
2020 Federal Poverty Guidelines	Max Annual Income Amts for ea Sliding Fee % Category (except for 0% Discount)											

8. **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. <u>If you subpoena me or records I will obtain an attorney to oppose it in order to preserve the extremely important therapeutic relationship</u>. Harm may result in the clinical relationship when providers are forced to testify and to share treatment information regarding their children clients. If children client's confidentiality is betrayed it may risk loss of therapeutic alliance and trust.

Despite this should client subpoena therapist to testify in court about therapy sessions, therapist testimony in court is limited to statements of fact about therapy sessions conducted with client and attending parties. Therapist is NOT qualified to offer opinions in matters of custody, parental fitness, and topics beyond the scope of the therapy sessions. Therapy sessions are protected by HIPAA and client/therapist confidentiality will be invoked during testimony, except where explicit or implied consent has been given by all parties attending those sessions being addressed. The judge may order therapist to testify, and therapist may appeal judge's order under certain extraordinary circumstances. Therapist fee is $500/hour, "door-to-door", regardless of whether therapist testifies, with a $1000 retainer due prior to the court date. If it is not paid for prior to giving testimony, therapist will inform the judge of that fact.

9. **BILLING**

Should you use insurance benefits, you authorize the release of any medical or other information necessary to process this claim and payment of medical benefits to the undersigned supplier of services (therapist). You also request payment of government benefits either to yourself or to the party who accepts assignment below (therapist). You acknowledge that some specific services are not a covered benefit by insurance and agree to pay, for example, many insurance companies including Medicaid do not cover couples counseling, or non-Axis I diagnoses, and clients are responsible for paying for that.

10. **LATE CANCELLATION/NO SHOW/TERMINATION POLICY AGREEMENT**

You shall keep all scheduled appointments, unless a personal emergency occurs, and shall give notice of at least 24 hours of intention to cancel your appointment. If you leave a message, the date and time of the message will be notice. Cancellations for Monday sessions need to be cancelled by the end of business day (5pm) on Fridays. If appointment is canceled less than 24 hours, you will be charged a full session fee, unless an emergency occurred determined by therapist. Grace is always given for sickness and unsafe weather/road conditions. You will be responsible to schedule the next appointment. If you do not then Therapist will call once to clarify your wish to continue or end therapy. If you do not respond within a week, therapist will document closure with any reason. Therapist reserves the right to end therapy when appropriate and ethical. We refuse services for safety reasons. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time. Melissa Bannerot 719-310-6357 CO LSW 773. In the event that she is unable to perform this function then it will be Beverly Gardner at 719-660-5281 CO LPC 1820.

11. **RESPONSIBILITIES, PAYMENT FOR THERAPY FINANCIAL AGREEMENT**

Your appointments will usually be 45 to 55 minutes, posted and charged the standard rates, or sliding fee scale with documentation of your household monthly/annual income.

As the financially responsible person for the account you are ultimately responsible for all fees described in this agreement and will pay at time of check-in for all portions of services due in full at the time services are provided by therapist. Payment methods accepted: Cash, Personal Check, or debit or HSA card via Electronic Payment Agreement using Stripe in Simple Practice. A $25 NSF insufficient fund charge is assessed for returned/declined checks/payments, and checks that are not paid within 2 weeks of being returned to Therapist's office are handled as unpaid bills. Payments after 30 days may be assessed late fees. Fee for not paying at time of service is 10%. Unpaid bills may be submitted to collection services, credit reports, court, and the local district attorney's office. You will then be required to make all payments in cash. In persistent cases a discharge from the practice may be appropriate for nonpayment situations. You and collaterals will be charged for phone consults of 16 minutes and more with therapist based on the standard rates below with a minimum 30 minutes rate. Office hours are 9:00 a.m. to 5:00 p.m. Copy requests are $10/1st 300pp + $1/25pp after that.

12. **TREATMENT AGREEMENT CONSENT AND AUTHORIZATION**

By signing below I agree to abide by these accepted policy terms of service regarding treatment, disclosure, payment, privacy, late cancellations/no show, fees, billing, and rights. I authorize Therapist to provide psychotherapy assessment and/or mental health treatment/services, which may include EMDR therapy, and may include touch, to me as a client/consumer. I have had an opportunity to discuss this with therapist.

I have read all the information herein and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement if requested. I know my rights as a client or as the client's privilege holder and enter this agreement.	
Print Client's name(s):	**Date:**
Client's or Privilege Holder's **Signature(s):**	
Client's or Privilege Holder's **Relationship(s):**	

For a Minor, who gets to make decisions for this child?

□ Guardian ad litem appointed, collateral privilege holder instead of parents

□ Child legal representative

PLEASE CHECK BOX INDICATING marital status of parents:

□ Married (Need either parent's consent, who is collateral privilege holder)

□ Never married, never a court order appointing decision-maker (Need either parent's consent, who is collateral privilege holder)

□ Divorced/Court Order established allocation of parental responsibilities/decision-making **PROVIDE COPY**

□ Parent with Decision-Making for medical and/or mental health decisions is collateral privilege holder and can consent **OR**

□ Joint Decision-Makers (Need **both** parents' consent, who are collateral privilege holders.

- It is best practice that I make efforts to engage with both parents no matter how involved/not to ensure child is not later withdrawn from therapy later by an uninvolved parent viewing therapist as a hired gun and for co-parenting purposes)

Provider Statement

Therapist hereby personally and professionally commits to offering you these rights, providing you with the highest quality of service and responding to your needs in the most highly ethical manner, according to the professional standards of care in marriage and family therapy.

Therapist's Signature: _____Date: _____

Megan Silberhorn (970) 305-5886 | (307) 624-6254 (fax) | megan.silberhorn.aic@gmail.com
www.allinclusivecounseling.com