

DISCLOSURE STATEMENT

1. Karen D. Matuska, All Inclusive Counseling, Inc., 5540 North Academy Boulevard, Ste 210/250, Colorado Springs, CO 80918, (719) 581-7589 (Provider).

2. Provider graduated from Adams State University in August 2021 from a CACREP accredited Master of Arts program in Clinical Mental Health Counseling. Provider also graduated from Pacific Lutheran Theological Seminary in May 2009 with a Master of Divinity. Provider is a Licensed Professional Counselor Candidate in Colorado #0018757 and operates under the license and supervision of Leilani Cullen MA, LMFT, CO #913.

3 The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. Regulatory requirements applicable to mental health professionals:

- ◆ Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision.
- ◆ Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- ◆ Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- ◆ Certified Addiction Counselor II (CAC II) must complete additional required training hours & 2,000 hours of supervised experience.
- ◆ Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- ◆ Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
- ◆ Licensed Social Worker must hold a master's degree in social work.
- ◆ Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- ◆ A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

4. CLIENT RIGHTS AND IMPORTANT INFORMATION

- a. You are entitled to receive information from provider about your therapy methods, techniques used, duration (if known), and fee structure.
- b. You can seek a second opinion from another provider 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. Generally speaking, the information provided by and to the client in a professional relationship with provider is legally confidential and provider cannot disclose the information without client's consent. There are several exceptions to confidentiality which include: (1) I am *required* to report any suspected/known incident of child abuse (even if victim is an adult now if there's knowledge/reason to believe that perpetrator is in position of trust (clergy, teacher, parent), or elder (70yo+) abuse or neglect to law enforcement, even if it's already been reported, so you have the option of choosing how much to disclose; (2) I am *required* to make reasonable and timely effort to report any serious threat of imminent physical violence against a specific person(s), including specific location/entity to law enforcement and to the person(s) threatened; (3) I *may* report to school/district and law enforcement an articulable and significant threat or substantial bodily harm against a school or occupants or exhibits such behaviors; (4) 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, which may include a call to CO Crisis Support Line for a mobile evaluation which may result in a 72-hour hold, which I will not be liable for; (5) I am *required* to report any suspected threat to national security to federal officials; (6) I may be required by Court Order to disclose treatment information; and (7) I am *urged* to report to a county department reasonably believed or observed incidents or imminent risk of mistreatment (abuse, caretaker neglect and/or exploitation), and/or self-neglect of at-risk adults and elders (unable or lacks sufficient understanding or capacity to communicate responsible decision making or perform or obtain services needed for their health safety or welfare) not more than 24 hours after observation or discovery; IDD to law enforcement agency. You may read section 12-43-218, 18-3-401(3.5), 18-6.5-108, 19-3-304(1), 26-5-111, and 27-65-105 of the Colorado Revised Statutes C.R.S 25-1-802, and the HIPAA Privacy Rule Federal law 45 C.F.R 164.501 for further details. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: <http://www.dora.state.co.us/mental-health/Statute.pdf>.

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. 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 parents request treatment information from me, I may provide a treatment summary, in compliance with Colorado law and HIPAA Standards.

g. I agree not to record our sessions without your written consent; and you agree not to record a session or a conversation with me without my written consent.

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 provider as it is hard to predict the outcome of therapy.

i. To phone call provider 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. Provider is not available on an emergency basis.

j. **To text or e-mail for scheduling purposes only.** To protect your privileged and private confidential information by not texting or e-mailing 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 are 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 or the patient portal are 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 Advanced MD 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. To not have sessions recorded by you, members, or provider unless signed permission in writing is made in advance per session. Take notes.

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 provider 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-SUI CIDE	1-800-656-HOPE	1-800-TLC-T EEN	844-493-TALK(8255) text TALK to 38255 CO Crisis Support Line
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, provider 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 pursuant to the grounds established in section 12-43-222 or 12-43-226. (II) (A) Any person who alleges that a licensee, registrant, or certificate holder violated a provision of this article 43 related to maintenance of records of a client eighteen years of age or older must file a complaint or other notice with the board within seven years after the person discovered or reasonably should have discovered the misconduct. A licensee, registrant, or certificate holder shall notify a client that the client's records may not be maintained after the seven-year period for filing a complaint pursuant to this section. The required notice must be provided to the client in writing no later than one hundred eighty days after the end of the client's treatment. The notice may be included with the licensee's disclosures pursuant to section 12-43-214 (1) or sent to the client's last-known mailing address. Consistent with all procedural requirements of this article 43, or otherwise required by law, the board must either take disciplinary action on the complaint or dismiss the complaint no later than two years after the date the complaint or notice was filed with the board. (B) The seven-year limitation period specified in subsection (1)(a)(II)(A) of this section does not apply to the filing of a complaint or other notice with the board for any other violation of this article 43, including the acts described in section 12-43-222 or 12-43-226.

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 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 provider 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.

5. METHODS AND TECHNIQUES

Provider integrates Person Centered and Accelerated Experiential Dynamic psychotherapies in an existential framework. Provider is attachment- and trauma-focused. Issues of special interest are depression, anxiety, navigating life transitions, work stress, end of life, and exploring crises of meaning, values, and spirituality. Duration of treatment is determined collaboratively based on client need and progress.

6. OUTDOOR THERAPY

Spending time outdoors during counseling sessions can be very valuable and is an option when you meet with me. However, you must know that certain situations outdoors may lead to encountering the risk of others in the community seeing a counseling session take place. Similar to group counseling, confidentiality cannot be guaranteed in outdoor counseling settings. However, I will do my best to ensure your physical and emotional safety. Clients agree to inform the counselor of any medical issues that may impact client safety during outdoor sessions (examples include, but are not limited to, allergies or heart conditions).

7. NOTICE OF PRIVACY PRACTICES RECEIPT & ACKNOWLEDGMENT OF NOTICE

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

Client Refuses to Acknowledge Receipt

8. DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a provider 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. If you subpoena me or records, I will obtain an attorney to oppose it in order to preserve the extremely important therapeutic relationship. 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 provider to testify in court about therapy sessions, provider testimony in court is limited to statements of fact about therapy sessions conducted with client and attending parties. Provider 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 the Colorado Revised Statutes, and client/provider 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 provider to testify, and provider may appeal judge's order under certain extraordinary circumstances. Provider fee is \$300/hour, "door-to-door", regardless of whether provider testifies, with a \$600 retainer due prior to the court date. If it is not paid for prior to giving testimony, provider will inform the judge of that fact.

9. BILLING

Should you utilize 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 (provider). You also request payment of government benefits either to yourself or to the party who accepts assignment below (provider). 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 and clients are responsible for paying for that.

9.a. Surprise/Balance billing. Beginning 1/1/2020, Colorado state law protects you from "surprise" or "balance billing." These protections apply when: 1) You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or 2) you unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado. A complete list of client rights and responsibilities is available at

<https://www.colorado.gov/pacific/dora/out-network-health-care-provider-reimbursement>, at <https://www.allinclusivecounseling.com/>, or by request through the patient portal.

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 serve as the basis of when notice was made. If appointment is canceled at least one hour, but less than 24 hours, you will be charged \$25 for the scheduled

session (LATE CANCEL FEE). Cancellations of less than an hour will be considered a “NO SHOW” and you will be charged a full session fee, unless an emergency occurred determined by provider. The first time each of these occurs you will not be charged (grace). However, if this should occur a second time, you will be charged. Grace is always given for sickness and unsafe weather/road conditions. You will be responsible to schedule the next appointment within a week. If you do not then Provider will call once to clarify your wish to continue or terminate therapy. If you do not respond within a week provider will document termination of therapy. Provider will acknowledge termination by documenting it with reasons in the record. Provider reserves the right to terminate therapy when appropriate and ethical. We refuse services for safety reasons

11. RESPONSIBILITIES, PAYMENT FOR THERAPY FINANCIAL AGREEMENT

Your appointments will usually be 55 (adult/EAP), or 60-75 (trauma/family) minutes, posted and charged the standard rates, or sliding fee scale below 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 provider. Payment methods accepted: Cash, Personal Check, or debit or HSA card via Square or Electronic Payment Agreement. 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 Provider’s office are handled as unpaid bills. Payments after 30 days 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 may be charged for phone consults of 10 minutes and more with provider based on the standard rates below with a minimum 30 minutes rate.

12. SLIDING SCALE FEE WITH PROMPT PAY DISCOUNT AT TIME OF SERVICE see attached. Rates increase 5% each year on January 1st.

13. 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 Provider 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 provider.

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):		

Minor 12 years or older as privilege holder has authority to consent to treatment on their own behalf (CRS 12-43-202.5).

For a Minor under 12 years old, 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 provider as a hired gun and for co-parenting purposes)
- Any parent is entitled to receive referral information and/or a treatment summary of services given/needed with or without 1) decision-making authority (CRS 25-1-802) or 2) consent of the minor.
- AAMFT Ethical Principle 2.1 limits on confidentiality

Provider Statement

Provider 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 therapy.

Provider's Signature: _____ **Date:** _____

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Sliding Scale Worksheet for Karen D. Matuska

It is my policy to offer a limited number of sliding scale slots based on family size and income. Sliding scale rates are by therapist agreement and contingent on submitting the sliding fee discount application and availability of sliding scale slots. Rates are determined according to the following charts.

2018 Federal Poverty Line

# Persons in Household	100% of FPL	200% of FPL	300% of FPL	400% of FPL
1	\$12,140	\$24,280	\$36,420	\$48,560
2	\$16,460	\$32,920	\$49,380	\$65,840
3	\$20,780	\$41,560	\$62,340	\$83,120
4	\$25,100	\$50,200	\$75,300	\$100,400
5	\$29,420	\$58,840	\$88,260	\$117,680
6	\$33,740	\$67,480	\$101,220	\$133,880
7	\$38,060	\$76,120	\$114,180	\$152,280
8	\$42,380	\$84,760	\$127,140	\$169,520
Households with more than 8 members, add \$4,320 for each additional person.				

Source: 2018 HHS poverty guidelines

Note: This data is for the 48 Contiguous United States and D.C.

Income Level	Fee
>100%	\$0-25
100-125%	\$30
125-150%	\$35
150-175%	\$40
175-200%	\$45
200-250%	\$50
250-300%	\$60
300%+	\$70