MANDATORY DISCLOSURE STATEMENT

1. *Adrienne Gorlen, M.S., Ed.S, LPC, Boulder and the Pine Wellness, LLC, 5540 North Academy Boulevard, Ste 210, Colorado Springs, CO 80918, (719) 445-6569 (therapist).*

2. Therapist graduated from Indiana University-Bloomington with a Master of Science in Counseling and Counselor Education, and an Education Specialist Degree with an emphasis in Mental Health and is a Licensed Professional Counselor in Colorado #13847 and an inactive LPC in South Dakota and Michigan. Therapist has worked for a crisis center and several hospitals since 2010.

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. The following are 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-masters 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 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. Generally speaking, the information provided by and to the client in a professional relationship with therapist is legally confidential and therapist cannot disclose the information without client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child or elder (70yo+) 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; and (5) I may be required by Court Order to disclose treatment information. 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. 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.

h. 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 may be available after hours to assist in acute, non-emergent situations, stated in your individualized treatment and/or safety plan; see section 4.m.

i. To text or e-mail for scheduling purposes only, or session emails, if opted in (see section 6.d). 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 is used to transmit and receive health information to and from requested parties with consent.

j. 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 therapist unless signed permission in writing is made in advance per session.

k. 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 do not accept clients as fans of my professional Facebook page. To know my listings on any site like square, yelp, etc. are not requests to add a review, testimonial, rating or endorsement.

l. 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.

m. 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	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				

n. 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.

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. 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 MFTs 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.

6. METHODS AND TECHNIQUES

a. Therapist integrates Dialectical Behavioral Therapy, Acceptance and Commitment Therapy, and yoga therapies and techniques with a strengths-based approach, utilizing the evidence-based treatment modality appropriate to the client and presenting issues. Issues of special interest are anxiety, depression, adjustment, and self-esteem.

b. Duration of therapy is determined by need and measured progress.

c. Location of counseling session is negotiable. Therapist will do their best to maintain client confidentiality, but client recognizes that there are risks associated with Therapist being seen with client in public.

d. Clients have the ability to opt in to an email or letter between sessions summarizing the previous session and goals:

□ Client **opts in** to email between sessions and acknowledges section 4.i related to confidentiality of email. Please provide email: _____

□ Client **opts in** to a letter between sessions and acknowledges that therapist will send letter via the United States Postal Service (USPS) and accepts all risks and responsibilities regarding confidentiality associated with use of USPS mail. To protect client privacy, letter will have All Inclusive Counseling's address only as a return label, in case letter is deemed undeliverable. Please provide the address and attention line, as you would like to receive it:

_____

_____

_____

7. NOTICE OF PRIVACY PRACTICES RECEIPT & ACKNOWLEDGMENT OF NOTICE

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

_____ (initial) Client **refuses** to acknowledge receipt of Notice of Privacy

8. BILLING

Should you utilize insurance benefits, you authorize the release of any medical or other information necessary to process this claim. You also request payment of government benefits either to yourself or to the party who

accepts assignment below (therapist). You authorize payment of medical benefits to the undersigned supplier of services (therapist). All payments on the part of the financially responsible person for the account, including but not limited to co-pays, sliding scale fees, and phone consultations, are due at time of service. See section 10.

9. **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 $30 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 therapist.

The first time one 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 Therapist will call twice to clarify your wish to continue or terminate therapy. If you do not respond within a week therapist will document termination of therapy. Therapist will acknowledge termination by documenting it with reasons in the record. Therapist reserves the right to terminate therapy when appropriate and ethical.

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

Your appointments will usually be 30 (child), 45 (adult/EAP),or 60 minutes (group) unless otherwise agreed upon, and you will be charged the standard rate, unless otherwise determined by the scholarship application.

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 appointment for all portions of services due in full at the time services are provided by therapist. Payment methods accepted: Cash, Personal Check, or debit 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 Therapist's office are handled as unpaid bills. 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 8 minutes and more with Therapist, pro-rated based on the standard 45 minute rate below:

11. **FEES for Counseling and Private Therapeutic Yoga** **effective 5/1/2019**

Individual Service:	Standard Rate	Group Service:	Standard Rate
Initial	155	2-3 people	60
30 min	61	4-6 people	45
45 min	85	7-10 people	28
60 min	100	11-20 people	22

12. **TREATMENT AGREEMENT CONSENT AND AUTHORIZATION**

By signing below I agree to abide by these accepted 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 yoga therapy, and may include touch, to me as a client/consumer.

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 responsible party.		
Client's name (15 years old or older)	Client's or Responsible Party's **Signature**	**Date**
If signed by Responsible Party, please state relationship to client and authority to consent:		

A) **Minor 15 years or older** have authority to consent to treatment on their own behalf (CRS 27-65-103).

B) **Minor under 15 years old**, PLEASE CHECK BOX INDICATING marital status of parents:

□ Married (Need either parent's consent)

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

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

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

Joint Decision-Makers (Need **both** parents' consent) other responsible party_____

Any parent is entitled to receive a treatment summary of services given/needed with or without 1) decision-making authority (CRS 25-1-802) or 2) consent of the minor.

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 professional counseling.

Therapist's Signature: _____ Date: _____

Adrienne Gorlen, MS, Ed.S, LPC 5540 N Academy Blvd Suite 210 Colorado Springs, CO 80918 (719) 632-5033

_____ Scholarship application received