Disclosure Statement

Mandatory Disclosure of information to Clients

Heather Proulx, MA , LPCC
(Licensed Professional Counselor Candidate #15266)
All Inclusive Counseling, Inc.
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Please read this document carefully, as it contains important information about informed consent, my policies, and how your mental health information can be used and disclosed. All Inclusive Counseling will be referred to as AIC throughout the remainder of this document.

1. INFORMED CONSENT

Informed consent is a legal and ethical term defined as the *consent* (permission of or agreement to) services, and for the consent to be *informed,* the client must first achieve a clear understanding of the relevant facts, risks and benefits, and the available alternatives.

What to expect: Therapy is a collaborative process, requiring your very best effort, honesty, and openness in order to achieve desired changes. I attempt to help identify and develop the best therapeutic plan to address issues, thoughts, or emotions that may be interfering with your personal growth and goals while providing a safe place to grow and to find a healthy source of motivation and/or inspiration. This process can possibly result in your experiencing emotional discomfort. Change will sometimes be easy and swift; other times it will be slow and frustrating. We will develop a Treatment Plan with goals and learn of the benefits and risks associated with certain therapeutic approaches, and the anticipated frequency, with no guarantee that therapy will yield the results you want or desire. At all times, it is your decision whether to pursue the suggestions made and it is always your responsibility to make decisions regarding change. Along with individual sessions, family or couples counseling/intervention may also be suggested if I see that it would best serve you.

2. CLIENT RIGHTS AND IMPORTANT INFORMATION

You are entitled by law to receive information about the methods of therapy, techniques used, duration of therapy (if known), and the fee structure.

a. During the course of therapy, various therapeutic approaches will be drawn upon, according to the problem that is being treated and my assessment of what will best benefit you.
b. You may seek a second opinion from another counselor/therapist or terminate therapy at any time.
c. If your challenges lie beyond the ability of my expertise, then I am legally required to refer, terminate, or consult. I will discuss this with you, offer you appropriate referrals, and end treatment.
d. In ANY professional relationship (such as ours), sexual intimacy between the professional and a client is never appropriate and should be reported to the Department of Regulatory Agencies, Mental Health Section that licenses, registers, or certifies the licensee, registrant or certificate holder. Contact information is provided below under REGULATIONS.
e. Confidentiality: By law, you have the right to confidential therapy. Generally speaking, the information provided by and to the client during therapy sessions is privileged communication and will not be released nor disclosed without your written consent. There are several exceptions to the general rule of legal confidentiality where your rights to confidentiality are set aside and your therapist is required by law to report certain incidences to the

appropriate authority (Department of Human Services &/or law enforcement). These exceptions are as follows and are listed in the Colorado Revised Statutes (section 12.43.218 C.R.S.):

1) Any information disclosed suggesting neglect, physical abuse, incest, or sexual abuse against child or elder 70yrs+ (even if victim is an adult now if there's knowledge/reason to believe that perpetrator is in position of trust- clergy, teacher, parent)
2) 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
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, which may include a call to CO Crisis Support Line for a mobile evaluation which may result in a 72-hour hold, for which I will not be liable
4) The duty to warn and protect someone else who is threatened by imminent danger, to include any suspected threat to national security to federal officials
5) Court-involved cases or litigation
6) Confidentiality of email or text cannot be guaranteed due to the innate nature of internet/cyber communication being lost in transit or viewed by a third party. Please use discretion when communicating via email or text and it is to be used for scheduling purposes only.
7) 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.

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.

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 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.
h. Therapy sessions may NOT be recorded by you or me without your and my written consent.
i. 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.
j. 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.

k. 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.

3. POLICIES

a. 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.

b. **Emergencies:** 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, 24hour Suicide Prevention Lifeline: 1-800-273-TALK(8255); 1-800-SUICIDE; 1-800-656-HOPE; 1-800-TLC-TEEN; 1-844-493-TALK(8255), CO Crisis Support Line: Text TALK to 38255**

c. If a couple/family client needs individual therapy, the 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. If 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.

d. **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 investigate or evaluate and 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 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 the Colorado Revised Statutes, 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 $300/hour, "door-to-door" regardless of whether therapist testifies, with a $600 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.

e. **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. Cancellations for Monday sessions need to be cancelled by the end of business day (5pm) on Fridays. 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 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 Therapist will call once 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. 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. Leilani Keator at 5540 N Academy Blvd Ste 210 Colorado Springs CO 80918 719-632-5033 LMFT 913.

f. **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 below. If you have any questions regarding the Notice or your privacy rights, you may inform Therapist.

□ Client Refuses to Acknowledge Receipt

4. RESPONSIBILITIES, PAYMENT FOR THERAPY FINANCIAL AGREEMENT

a. **Insurance Billing:** Should you utilize insurance benefits, you authorize the release of any medical or other information necessary for client file, plan coverage/co-pay amount, claim processing (Medicaid only), and payment 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). For Medicaid benefits, you acknowledge that some specific services are not a covered benefit by insurance (like couples counseling) and agree to pay out-of-pocket for such services.

b. **Payment**: As the financially responsible person for the account/service, you are ultimately responsible for all fees described in this agreement and will pay in full at time of check-in or immediately following each session for all services provided by therapist. Most insurances do not accept claims for services provided by a LPCC (or any licensed candidate), thus payment will be considered out-of-pocket and your insurance will not be billed. For payment amount, your insurance's copayment fee will first be matched OR payment will be based on a sliding scale fee should the copayment be less than $50 for individual/ $65 for couples. Payment methods accepted: Cash, Personal Check, or debit or HSA card via Square or Electronic Payment Agreement. A $2.00 fee will be added for debit, credit or HSA payment processing and 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 are 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.

c. **Session length:** Your appointments will usually be 45-60 minutes (adult/EAP), or 60-90 minutes (trauma/couples/family)

5. EDUCATION/CERTIFICATION

- Masters (M.A.) degree in Counseling and Human Services from the University of Colorado at Colorado Springs (UCCS) in May 2003
- Bachelors (B.A.) degree in Psychology from the University of Colorado at Colorado Springs (UCCS) in May 1998
- School Counseling endorsement from the University of Colorado at Colorado Springs (UCCS) in May 2010
- I hold a current license (#15266) with the state of Colorado as a Licensed Professional Counselor Candidate

Relevant Experience:

- Therapist for acute adults, adolescents and children at Cedar Springs Hospital (psychiatric hospital)
- Therapist for Children's Partial Hospitalization Program
- Individual, couples, family, & group therapist
- Foster care & adoption placement supervisor
- School Counselor
- Families involved in DHS (Department of Human Services)
- Family Preservation Specialist

Expertise: Individual, relationships/couples, and family/parenting. Self-Growth, Self-Realization, Conflict Resolution (personal and interpersonal), Healthy Communication, Sub-Conscious work, Life Transitions (to include grief & loss), Mood Disorders, Children/Teens with challenging behaviors (treated within the family context), and Nutrition

6. TECHNIQUES & APPROACHES

I will help facilitate self-reflection and insight into behavior programming, accountability, and coping abilities, and your perceptions may be challenged with directive, instructional, and healthy confrontation.

My therapeutic approach is *Eclectic Therapy*, which uses a combination of therapies tailored to the needs of the individual. I typically draw from the following therapy modalities:
Cognitive-Behavioral Therapy (CBT) focuses on adjusting cognitions, assumptions, beliefs and behaviors, with the aim of influencing troubled emotions. The goal is often to identify irrational thoughts and beliefs that are related to negative emotions that may produce harmful behaviors and replace them with more realistic and self-help alternatives.

Dialectical Behavior Therapy (DBT) focuses on mindfulness, interpersonal effectiveness, distress tolerance, & emotion regulation.
Solutions Focused Therapy focuses on identifying and discussing the problem, understanding its source, and how to best address it.
Emotion-Focused Therapy (EFT) works through emotions to help change problematic emotional states and interpersonal relationships by focusing on attachments and bonding.
Person-Centered is foundational. Genuineness, unconditional positive regard, and empathic understanding is essential for a client's growth.
Family systems/Systemic is a form of psychotherapy that helps individuals resolve their problems in the context of their family units, where many issues are likely to begin. Each family member works together with the others to better understand their group dynamic and how their individual actions affect each other and the family unit as a whole.
*Trauma Informed Care (TI*C) and *Trust-Based Relational Intervention (TBRI)* are ways to approach and treat patients, particularly children/adolescents, with trauma backgrounds, including in-utero trauma from stress and increased cortisol levels.
Collaborative and Proactive Solutions (CPS) focuses on identifying particular "lagging" skills and the expectations that are difficult to meet, rather than focus on the challenging behavior itself or psychiatric diagnosis, then utilize a particular model that builds a collaborative and proactive partnership between parent(s) and child(ren).
Other: Techniques from Complementary and Alternative Medicine and Psychology are also offered, such as spiritual counseling, EMDR (Eye Movement Desensitization and Reprocessing), TAT (Tapas Acupressure Technique), Meridian-guided practices/acupoint stimulation, Applied kinesiology/muscle testing, and nutrition. Ask if interested.

7. 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 assessments and/or mental health treatment/services, which may include EMDR therapy and may include touch, to me as a client/consumer.

I have read all the information herein and it has been reviewed with my therapist. 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? Please check appropriate box:
□ 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 the degree of parental involvement, for co-parenting purposes and to ensure child is not later withdrawn from therapy by an uninvolved parent viewing therapist as a hired gun
- 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

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: _____

Heather Proulx, MA, LPCC

I encourage you to commit to your journey of emotional, mental, and spiritual well-being to the best of your ability. I have full belief and confidence that your commitment and motivation, even through the seemingly darkest places, will benefit you mentally, emotionally, & physically and lead you to higher awareness, insight and growth. Ultimately, as you embark on your journey, you can expect confidential, authentic, supportive, and valued treatment! ~Heather

REGULATIONS

The Colorado Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of the following licensed professionals: psychologists, social workers, professional counselors, marriage and family therapists, certified addiction counselors, and school psychologists practicing outside the school setting, and unlicensed individuals who practice Psychotherapy. Questions or complaints may be addressed to:

Department of Regulatory Agencies
Mental Health Section
1560 Broadway Blvd., Suite 1350
Denver, CO 80202
303.894.7766