MANDATORY DISCLOSURE STATEMENT

1. Leilani Keator, M.A., LMFT, All Inclusive Counseling, Inc., 5540 North Academy Boulevard, Ste 210, Colorado Springs, CO 80918, (719) 632-5033 (Therapist).
2. Therapist graduated from Argosy University in 2000 with a Master of Arts in Professional Counseling with an emphasis in Marriage and Family Therapy and is a Licensed Marriage and Family Therapist in Colorado #913 and an inactive MFT in Hawaii #240. Therapist has been in private practice in CO since 2009 and worked for several HI or CO mental health agencies since 2007 and 2009 respectively.
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 Marriage & Family Therapist 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-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/known incident of sexual 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 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 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 therapist unless signed permission in writing is made in advance per session.

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	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, 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 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 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.

5. **METHODS AND TECHNIQUES**

Therapist integrates trauma-informed mindfulness-based Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Emotionally Focused Therapy, Solution-Focused Therapy, Acceptance and Commitment Therapy, Motivational Interviewing, and systemic therapies and techniques with a strengths-based approach, utilizing the evidence-based treatment modality appropriate to the client and presenting issues. Therapist is trained in Eye Movement Desensitization Reprocessing (EMDR) therapy, Gottman Level I, and EFT externship trained. Issues of special interest are relationships, parenting, trauma, ADHD, anxiety, and depression. Duration is determined by need and measured 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. **INFORMED CONSENT TO RECEIVE TELEHEALTH PSYCHOTHERAPY SERVICES**

This is for Tele mental health* services with AIC Provider. Social distancing is the most effective way to slow the transmission of the Coronavirus that causes COVID-19. In an effort to continue to provide quality mental health services, we are offering the option of online psychotherapy services. It is essential to understand your rights and responsibilities. I understand that "telehealth" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental health information, both orally and visually. I understand that I have the following rights with respect to telehealth:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- I have the right to confidentiality. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are mandatory exceptions to confidentiality which were discussed in the *Mandatory Disclosure Statement (MDS) / Informed Consent* reviewed with me at the start of services.
- I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
- I understand that risks and consequences from telehealth may include but are not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I will be notified immediately in the event of a breach of confidentiality or data.
- I understand that telehealth based services and care may not be as complete as face-to-face services. If my counselor believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I may be referred to a professional who can accommodate. All referrals will adhere to the provider's Professional Code of Ethics.
- I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even worsen.
- I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. Some benefits are:
    - Fewer limitations by geographical location, and possibly more options for scheduling times to meet.
    - Reduction of travel to a physical office, which reduces or eliminates travel time.
    - Participation in therapy from your own home or the environment of your choosing.
- I understand that no video or voice recordings are to be made, captured, or kept from telemental health sessions unless approved in writing. Clients may not record or store video conference sessions or face-to-face sessions.
- I understand that at the beginning of each session, I must disclose my location to my therapist in case an emergency arises during the session.

- I accept that telehealth does not provide emergency services. During our first session, my therapist and I will discuss an emergency response plan.

***If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the Colorado Crisis Services at 1-844-493-TALK (8255) is a 24/7/365 support line for anyone affected by a mental health, substance use or emotional crisis. Immediate support is available and connections to more resources are provided, or I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

- I understand that I am responsible for (1) Minimum bandwidth connection of 384 kb or higher. (2) Minimum resolution of 640x360 at 30 frames per second. (3) Operational web camera (HD 1080p is recommended). (4) Proper lighting and seating to ensure a clear image of each party's face. (5) Dress (clothing) and physical environment that would be appropriate for an in-office visit (solid color attire maximizes quality). (6) Only previously agreed-upon participants are permitted to be present or to participate, observe, or hear the session in any way. The presence of any individuals unapproved by client & therapist and not part of the treatment plan will be cause for termination of the session. (7) Valid ID must be presented by the client during the initial consultation. In addition, a copy must be provided by the client to be held in the therapist's file; however, initial sessions are encouraged to be held in person when possible. (8) The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session. (9) The client shall also provide a phone number where they can be reached in the event of internet service disruption. (10) The full fee will be charged even if technical or equipment problems (on the client's end) or violations of any of these Client Agreements occur and prevent the completion of your session.

Payment

- Payment for services is made under the same practice guidelines as with in-office sessions.

Protocols for Technical Failure:

- If equipment or transmission failure occurs,I will first disconnect and attempt to reconnect with the telehealth therapy platform. If unsuccessful, the therapist will use the phone number provided in the intake form to reach out to me and try to resolve issues. It may be necessary to complete the session via telephone.
- To protect confidential information, I may be asked to provide a codeword or answer a security question before continuing (or initiating) a counseling session over the phone.
- If the technical difficulties can be resolved quickly, the session will resume and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, another session may be scheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for continuation of services.

Colorado Law:

- I understand that most states require healthcare providers to be licensed in the state in which the Telehealth patient is located. In order for Provider to provide telehealth services to me, I (Patient's off/distant site) need to be in the state of Colorado.
- Since Colorado passed telehealth parity law in 2016, private insurers are required to cover telehealth in the same manner that the plan covers health care services delivered by a provider in-person for patients statewide. To learn more about the telehealth reimbursement of private payers, I am responsible to contact my insurance company directly.

To access your telehealth sessions, you need:

1. A fully charged computer, tablet, or phone.
2. An external or integrated webcam.
3. An external or integrated microphone.
4. An internet connection with the bandwidth of at least 10 MBPS or Ethernet cable.

Recommendations for Client Session Space:

1. Find a quiet uninterrupted space. Children and pets are better not included in sessions.
2. Use headphones / earbuds during the session for more privacy.
3. Sit facing indirect light as much as possible, so that your face is visible to your therapist.
4. Adjust your camera to establish natural eye contact with your therapist.
5. Turn off computer & phone notifications by using "Do Not Disturb" just as you would in your in-person counseling sessions.
6. Wear solid color clothes to reduce pixel/ bandwidth
7. Close any other open apps and programs on your computer—they can rob you of processing power and degrade your signal. Desktops & Laptops tend to work slightly better than iPads and smartphones.
8. If you do not do a lot of videoconferencing, give yourself a break as you adjust to a slightly different rhythm of conversation than we have in-person.

Protocols for Technical Failure:

If equipment or transmission failure occurs, first disconnect and attempt to reconnect with the telehealth therapy platform. If unsuccessful, the therapist will use the phone number provided in the intake form to reach out and try to resolve issues. It may be necessary to complete the session via telephone.

I voluntarily agree to receive Telehealth assessment, care, treatment, or services and authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive at

any time. By signing this consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

8. **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

9. **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	29	26.10	23.20	20.30	17.40	14.50	11.60	8.70	5.80	2.90	0.00	0.00
90791 Initial Dx Assessment	166	149.40	132.80	116.20	99.60	83.00	66.40	49.80	33.20	16.60	0.00	0.00
90832 16-37 min Session	83	74.70	66.40	58.10	49.80	41.50	33.20	24.90	16.60	8.30	0.00	0.00
90834 38-52 min Session	133	119.70	106.40	93.10	79.80	66.50	53.20	39.90	26.60	13.30	0.00	0.00
90837 53+ min Session	139	125.10	111.20	97.30	83.40	69.50	55.60	41.70	27.80	13.90	0.00	0.00
90846 Family w/o Client 26+ min	128	115.20	102.40	89.60	76.80	64.00	51.20	38.40	25.60	12.80	0.00	0.00
90847 Family with Client 26+min	166	149.40	132.80	116.20	99.60	83.00	66.40	49.80	33.20	16.60	0.00	0.00
90839 Crisis 30-74 min	185	166.50	148.00	129.50	111.00	92.50	74.00	55.50	37.00	18.50	0.00	0.00
90840 Crisis Add'l 75+30 min	89	80.10	71.20	62.30	53.40	44.50	35.60	26.70	17.80	8.90	0.00	0.00
90853 Group 45 min(30minKids)	51	45.90	40.80	35.70	30.60	25.50	20.40	15.30	10.20	5.10	0.00	0.00
99404 EAP Preventive	122	109.80	97.60	85.40	73.20	61.00	48.80	36.60	24.40	12.20	0.00	0.00
H0001 Substance Use Screening	108	97.20	86.40	75.60	64.80	1566.00	43.20	32.40	21.60	10.80	0.00	0.00
H0004 Substance Use Treatment	34	30.60	27.20	23.80	20.40	2822.00	13.60	10.20	6.80	3.40	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)

10. 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 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.

11. 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. 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.

12. 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 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. 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 5540 N Academy Blvd Ste 250 Colorado Springs CO 80918 719-310-6357 LSW 773. In the event that she is unable to perform this function then it will be Beverly Gardner at the same address, 719-660-5281 LPC 1820.

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

Your appointments will usually be 30 (child), 45 (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 therapist. 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 Therapist'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 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.

14. **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):**	

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 therapist 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

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:_____

Leilani Keator, M.A., LMFT 5540 N Academy Blvd Suite 210 Colorado Springs, CO 80918 (719) 632-5033(Office) 719-264-7697 (fax) leilanikeator@gmail.com www.allinclusivecounseling.com