COUNSELING INFORMATION, DISCLOSURE AND INFORMED CONSENT STATEMENT

Psychotherapist: **Elizabeth Poole, LPC**. Located at **6970 S. Holly Circle, Suite 204, Centennial, CO 80112.** Telephone: **303.741.4046**. Fax: **303.771.1797**.

My education is as follows: Master of Arts, Psychology, The Naropa Institute, Boulder, Colorado. Bachelor of Arts in Business and Psychology, Regis University.

I am registered with the state of Colorado as a Licensed Professional Counselor (License number 921). I have been working with clients in Psychotherapy since 1992.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado *80202, (303) 894-7766.*

Client Rights, Responsibilities and Important Information

a. You are entitled to receive information from me about my approach to and methods of therapy, the duration of your therapy (to the extent I can determine it), and my fee structure. Please ask if you would like to receive this information.

b. You may seek a second opinion from another therapist or terminate your therapy at any time.

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs between any therapist and client, it should be reported to the Department of Regulatory Agencies, Mental Health Section.

d. ***Confidentiality*** Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the state of Colorado without the consent sought of the person to whom the testimony relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. There are exceptions that I will identify with you as the situations arise during therapy.

When I judge it would be helpful to the client's therapy, I may consult with specialists, other colleagues and other professionals. When speaking with other professionals, I make every reasonable effort to disguise identifying information about a client. All other mental health professionals with whom I consult are, like me, bound by confidentiality.

When a client has been referred directly to me by another person I like to thank the person for the referral. If you prefer I **not** thank them please initial here _________

e. ***Length of Sessions***. Standard sessions are 45-50 minutes. When a session exceeds 50 minutes, the fee for each additional 15 minutes or fraction thereof is *one fourth of my hourly fee*. This fee structure may be modified, by mutual agreement, at any time.

f. ***Cancellation/Rescheduling:*** When you *cancel or reschedule a* therapy appointment, I request at least 24-hours notice. Your scheduled sessions are your time and my time reserved expressly for you. Thus, if you *cancel, reschedule or fail to show* for an appointment with less than 24-hours notice, payment for the canceled or rescheduled session is required. Insurance does not cover late cancellations or failed appointments, therefore they are your responsibility. Thank you. Client's initials here: _______

If you have any questions or would like any additional information, please ask me. Please provide the following information in full. Thank you.

I have read the above information and understand m rights and responsibilities as a client.

X ____ ____
Client signature Today's Date

____ ___________ ______________________________
Client name *(please print)* Date of Birth Occupation

_____________ ______________ ____
Client phone number(s) Client Address City State Zip

In case of emergency please contact: ____
Name Relationship Phone Number

____
Name Relationship Phone Number

Referral Source (How did you find me?) . ____

X ___________________________________ ______________________________
Psychotherapist signature Today's Date
Elizabeth Poole, LPC #921