PSYCHOTHERAPY DISCLOSURE STATMENT

Leslie Rogers, MA, LPC, NBCC, L.L.C.
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Castle Rock, CO 80104 (303) 814-5411

1. ABOUT MY PSYCHOTHERAPIST

I hold a Masters level degree in Counseling and Human Services from the University of Colorado, Colorado Springs. I have completed and earned certificates for 34 hours of direct training in EMDR levels I & II. My theoretical approach is Cognitive-Behavioral Therapy (CBT) and Person-Centered Therapy. I am a certified Dr. Phil Life Strategist. I hold a License of Professional Counselor (LPC) in the State of Colorado, and am a National Board Certified Counselor (NBCC), and the American Counseling Association (ACA).

2. ABOUT MY CLIENT RIGHTS

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, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the State Grievance Board, 1560 Broadway, Suite 1340, Denver, Colorado 80802, (303) 894-7766.

Client Rights and Important Information:

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

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 between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client’s consent.

e. Information disclosed to a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, or a licensed psychologist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

f. There are legal exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (see section 12-43-218, C.R.S., in particular). There are legal exceptions to the general rule of legal confidentiality. The exceptions Include: intent to harm others or yourself; abuse or suspected abuse of children, and possibly the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child-custody, divorce and other court cases. Also, be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you as the situations arise during therapy.

g. I agree to pay **$105** for a psychotherapy appointment. Psychotherapy is provided in a 45 to 50 minute clinical hour on a 60-minute clock hour.

3. AS A PSYCHOTHERAPY CLIENT I UNDERSTAND THAT

a. I understand that Leslie Rogers will not (at the request of the client) testify in court as an expert witness, including: divorce, child custody, or criminal cases. I understand that Leslie Rogers will not release information to or communicate with another therapist (holding any scholastic degree), a child advocate, an attorney, or any other professional requiring confidential therapy information. This applies even if the client authorizes, with a written or verbal request, the release of Leslie Rogers' confidential client files. I understand that my personal client file belongs to my therapist.

b. I f my therapist is subpoenaed by the Court, I understand that court testimony on my behalf is charged at a higher rate of **$175.00** per hour including: testimony related matters like case research, report writing, travel, depositions, actual testimony and cross examination time and courtroom waiting time. Signing this disclosure statement gives permission for me to release confidential information in courtroom testimony and written reports to the Court *if* legally requested by the Court.

c. I consent to evaluation and mental health treatment for myself. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment.

d. I understand that Leslie Rogers is *not* a "crisis" therapist. If I have a life threatening emergency, I will need to call the Suicide and Crisis Hotline (303) 860-1200, the police (911) or go to my nearest emergency room. I understand that if my therapist thinks I need more intensive services I will be referred a therapist or organization that has the ability to provide treatment to meet those needs.

e. I understand my psychotherapist provides non-emergency psychotherapeutic services by scheduled appointment. If my psychotherapist believes my psychotherapeutic issues are above her level of competence, or outside of her scope of practice, she is legally required to refer, terminate, or consult.

f. I understand that there may be times when my psychotherapist may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my psychotherapist and the professional consulted. Signing this disclosure statement gives my psychotherapist permission to consult as needed to provide professional services to me as a client.

g. I understand that in marriage and family counseling, my psychotherapist holds a “NO SECRETS” policy. All members of the couple or family system are treated equally and “secrets” are not kept by the psychotherapist that require differential or discriminatory treatment of family members. I understand that any information shared in individual therapy MUST be also shared in couple or family therapy to insure this “NO SECRETS” policy. Signing this disclosure statement affirms permission to share this confidential information.

h. I understand that if I have any questions or would like additional information, I may ask during the initial session and any time during the psychotherapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in psychotherapy when deemed necessary by myself or my therapist.

i. I understand that I am legally responsible for payment for my psychotherapy services, <u>if, for any reason</u>, my insurance company, HMO, third-party payor, etc. does not compensate my therapist. I also understand that signing this form gives permission to my psychotherapist to communicate with my insurance company, HMO, third-party payor or anyone connected to my psychotherapy funding source.

j. I understand that if I do not give 24 hours prior notice of cancellation to my psychotherapist I will be charged the full fee for not showing up for a scheduled psychotherapy appointment.

k. I understand that, like any other professional service, I must pay for all psychotherapy services (psychotherapy in the office, telephone therapy, report writing, consultation, parental consultation, etc.) I receive as a client. If I do not pay for services received I understand I will be turned over to a collection agency to recover payment for my therapist. I also understand I must repay the full amount and any bank fees or other relevant costs to my therapist for bounced checks.

<u>CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AN CONSENT</u>

I have read the preceding information and understand my rights as a client. **By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement**. By signing this disclosure statement, I also agree to permit consultation and I provide release for my therapist to seek consultation with other psychotherapists or professionals as the need arises. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children that I am requesting psychotherapy services for from Leslie Rogers, LPC.

If you have any questions or would like additional information, please feel free to ask.

I have read the preceding information and understand my rights as a client/patient.

____	______________________________
Client/Patient Signature	Date
____	______________________________
Client/Patient Signature	Date
____	______________________________
Therapist	Date