Robyn Looze, LCSW, Psychotherapist
19563E Mainstreet, Suite204
Parker, Colorado, 80138
(720) 800- 3949

DISCLOSURE STATEMENT

First and foremost; I want you to know I realize finding a therapist is a difficult task as well as time consuming. I admire your courage and self- awareness to realize that you need some assistance navigating through life's challenges as many people do from time to time. I strive to establish and maintain a trusting and collaborative relationship with you. In addition, I take pride in being a caring, empathetic, honest, non- judgmental person. I am honored to assist you with your personal needs.

DEGREES AND CREDENTIALS

* Graduated from University of Denver with a Masters in Social Work, May, 2005
* Graduated from Metropolitan State College with a Bachelors in Social Work, May, 2004
* Licensed School Social Worker (License number) 0399447.
* Licensed Clinical Social Worker (License number) 9923397
* EMDR (Eye Movement, Desensitization and Reprocessing) level 2 practitioner
* DBT (Dialectic Behavioral Therapy) advanced training
* Play therapy (trained)
*Animal Assisted Therapy (certified dogs and trained handler)

Information you entitled to know:

REGULATORY REQUIREMENTS

Regulatory requirements applicable to mental health professionals: A Licensed Clinical Social Worker (LCSW), a Licensed Marriage and Family Therapist (LMFT), and a Licensed Professional Counselor (LPC) must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker (LSW) must hold a masters degree in social work. A 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 Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC II requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required. As a licensed professional in the state of Colorado, my practice as a psychotherapist is regulated by the state. If you are unhappy and/or have concern about what is happening during our therapy session, please share them with me

so I can respond to them and we can resolve them together. If you feel that your concerns have not been resolved you can contact the Department of Regulatory Agency at the Department of Regulatory Agencies 1560 Broadway, Suite #1340 Denver, Colorado 80202 at (303) 894-7766.

Colorado Mental Health Entitlements as a consumer:

Under the Colorado Mental Health Practice Statute, 12.43.214 CRS, you are entitled to receive information about the methods of clinical work, the techniques used, the duration of clinical work (if known), and the fee structure. You may seek a second opinion from another licensed or registered mental health professional or you may terminate our work at any time. In a professional relationship sexual intimacy is inappropriate and should be reported to the Board of licenses, registers, or certifies the licensee, registrant or certificate holder. Generally, the information provided by and to a client during sessions is legally confidential and cannot be released without the client's consent. Privileged communication 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. However, there are legal exceptions to the general rule of legal confidentiality which are listed in section CRS 12.43.218 and the HIPAA Notice of Privacy Rights you were provided with as well as other exceptions in Colorado and Federal law. Examples of some are as follows;

- 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, and or 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 registered or licensed therapist, legal confidentiality does not apply in a criminal or delinquency proceeding.
- There are other exceptions, such as threats to national security under the federal Patriot Act, which will be identified to you as the situations arise during therapy.

I have read and understand or discussed the preceding information above. I understand my rights and responsibilities as a client or the client's responsible party.

Client's Printed Name & Client or Responsible Party's: _____

Signature_____ Date_____

Structure of Therapy Sessions and What to Expect:

Psychotherapy takes work on your part. Moreover, it takes courage, strength and time to move through some disturbing thoughts and emotions, which may arise by discussing past and present experiences. Moving through some distressing or painful events is part of the process and will help you gain insight and understanding about yourself and others. Moreover, you will also be asked to do some work outside of the sessions, to ensure you get the optimal benefits of therapy. Rest assure you will not be alone during the process; I will be there to guide and support you as well as provide you with the tools and therapeutic techniques to help you during and after the sessions.

I do psychotherapy weekly or biweekly sessions of 60 to 90 minute periods. The Length or frequency of sessions can be increased or decreased depending on your needs and what modality is used. It should be noted that if you arrive late for a session, you are still responsible for the total fee of the session and the session will end at the time allotted for your visit. Peaceful Minds does not take insurance at this time: however, some clients are able to seek full or partial reimbursement from insurance companies by submitting a receipt of services, which I will be happy to provide you. Payments for services are due the day the session.

I except cash, checks and credit cards such as Visa and Master Card. In addition, too, a convenient, safe online payment method through a secure PayPal account. I understand people face hardship from time to time; therefore I reserve a set number of weekly sessions based on a sliding scale.

Therapy classes or seminars payment vary and are due at the beginning of the service provided. Sessions can be increased or decreased as needed; therefore, the cost will reflect any changes made. There is a $25 late fee for past due payments and a returned check fee of the $30 which will be added to the total amount. I understand that I am legally responsible for payment for my psychotherapy services, <u>if, for any reason</u>, a third-party payer does not compensate me. I also understand that signing this form gives permission for my psychotherapist to communicate to a third-party payer or anyone connected to my psychotherapy funding source. Failure to pay will be cause for termination of psychotherapy services.

Canceling Information and Scheduling:
You must call to cancel a session **<u>no less than 24 hours</u>** in advance of your scheduled time or you will be charged for the full therapy session. I understand life circumstance s sometimes gets in the way and they will be taken into consideration.

Phone Messages:
I will make every effort to return calls and/or emails within a 24 hour period, unless otherwise stated. I will attempt to check my messages during my days off; however, there is no guarantee I will get back to you within the 24 hours. In the event I do not get back to you in 24 hours, I will contact you on my next business day. In addition, I also understand that text, email, voicemail and phone are not secure lines of communication. Peaceful Minds therapy

will not be held liable for miscommunication, or any breach in confidentiality.

Electronic Communication
Feel free to email me regarding cancellations and scheduling changes. Please do not discuss confidential information in an email since it is not a secure method for private communication. My E- mail is robyn@peacefulmindstherapy.com.

Emergencies:
If you experience an emergency crisis for which you need immediate help, please be aware that I do not provide 24 hour crisis services. If you or your child needs immediate attention, please call 911 or visit the nearest emergency room. If either of you should go to the emergency room, please call to let me know.

Additional Information:
By signing this disclosure statement, I give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in psychotherapy when deemed necessary by me. They will also have to sign separate disclosure statements.

I understand that in family counseling, my psychotherapist(s) hold(s) a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the psychotherapist(s) 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.

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 decision making or parenting time allocation. 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 I write any reports to the court or to your attorney making recommendations concerning this issue.

Minors & Parents

Parents under 15 years of age who are **NOT** emancipated have the right by law to examine their child's treatment records unless the therapist feels viewing the records will cause harm to the child. Respecting the child's privacy plays an important role in building a comfortable and trusting relationship between child and therapist. Because the therapeutic relationship is so vital in making progress with this age group, I am requesting parents **NOT** to ask for a copy of their records. However, I will be happy to provide the parent/s with general information about your child's sessions and progress. In addition, I will provide a summary of your child's treatment after therapy has been terminated upon request.

Confidentiality is mandatory broken in cases where child abuse is suspected, in cases of harm to self; such as attempted suicide, and in cases where clear and imminent danger to others is threatened. By **initialing below** you agree to the request and information which will be provided to you.

Parent/ Guardian _____

Parent/ Guardian _____

CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, CONSENT

I understand that this form is compliant with HIPAA regulations and no medical or no psychotherapeutic information, or other information related to my privacy, will be released without permission unless mandated by Colorado law. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date. In addition, I have read and discussed the preceding information on each page and understand my rights and responsibility as a client or the client's responsible party.

Client's Printed Name & Client or Responsible Party's:_____

Signature_____ Date_____

Please sign below for your minor child, and/ or any of my minor children to receive psychotherapy services. 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 for whom I am requesting psychotherapy services here at Peaceful Minds Therapy.

Signature_____ Date_____