Seven Branches Counseling

CLIENT INFORMED CONSENT INFORMATION – Client _____

Welcome to Seven Branches Counseling. I will be continually working to provide you with appropriate, high quality services. I believe that a client who understands and participates in his/her care can achieve better results. I have the responsibility to give you the best care possible, to respect your rights, and to recognize your responsibilities as a client. I have prepared this information handout, which includes a notice of my privacy practices, to help you identify these rights and responsibilities.

I am a board certified, Licensed Professional Counselor Candidate (LPCC) in the state of Colorado. I have a Master's Degree in Clinical Mental Health Counseling from Denver Seminary, a Bachelor's Degree in Biblical Studies and 15 years of pastoral ministry experience. My license number is LPCC .0015911. My LPCC status allows me to provide Professional Counseling under the supervision of a Licensed Professional Counselor or equivalent while completing the requirements for licensure as a Professional Counselor. My supervisor is Elisabeth A. Sbanotto, PhD. Dr. Sbanotto obtained a Doctorate in Counselor Education and a Master's Degree in Counseling from Denver Seminary. She is a Licensed Professional Counselor with the state of Colorado (#12596) and National Certified Counselor (#95215).

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Licensed Professional Counselors can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

I can be reached by phone at 720-608-1777 or email at shawn@sevenbranchescounseling.com

YOUR RIGHTS AS A CLIENT

YOUR RIGHT TO PRIVACY AND CONFIDENTIALITY

This notice of privacy practices describes how information I maintain about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I follow the privacy provisions of state and federal laws and rules and of my profession's ethical standards. You have the right to know, through discussion with me and in writing, my policies and practices regarding the uses and protection of the information you will share with me and the limitations of privacy of your information. I may make changes in my policies and practices but if I do, I will inform you. Please keep a copy of this handout for your records.

The information I collect from you is needed for providing evaluation and treatment to you. I will inform you of the consequences, if any, of refusing to supply information I request. If you choose to not supply such information, I may be unable to determine which services are most appropriate for you and it will make it more difficult for me to carry out an effective treatment plan for you.

Your treatment record is accessible only to me and to personnel whom I have authorized to help me provide services to you. Your record includes your assessment, treatment plan, progress notes, psychological test reports, psychiatric and other medical reports, and closing summary.

Your billing record is also accessible only to me and to personnel whom I have authorized to perform billing services for you. In order to further protect your privacy and confidentiality I will attempt to avoid the use of e-mail to communicate with you in between our office appointments, only the telephone

You may choose to seek insurance reimbursement for payments made for provision of my services. I do not bill insurance companies on behalf of my clients. If, for some reason your insurance company requires more information about the services provided to you, you are responsible for providing Seven Branches Counseling with an **Authorization for Release of Information**. This Release of Information will provide the minimum information necessary for your insurance company to process claims and may include: your name, birth date, social security number, diagnosis, dates of service, type of service. Should your insurance company require further information, I will first consult you about your insurance company's request. I will give you the option to make an informed decision regarding what, if anything, you wish to be released.

All personnel – counseling, support, or billing – whom I authorize to have access to your health care information in this office will limit their access to and use of your health care information to the minimum necessary to fulfill their authorized respective functions for treatment and payment services. They have agreed to abide by the privacy and security practices of this office.

Your complete record will be retained for seven years after you have completed treatment. At the end of seven years, the record will be entirely destroyed, leaving only the name of the client and date of record destruction. The time period begins from the date of the last visit. (Or for minors, from the date they reach 18.) Should there be any further direct client contact, the counting period will begin again after the conclusion of the new service.

If you are receiving services from other health care professionals, I may need to routinely confer with them about your assessment, counseling plan, and progress for the purpose of coordinating your services.

At times I may also seek out professional consultation about some aspects of my work with you. Usually it will not be necessary to share your identifying information with the consultant(s). The consulting professional(s) also must abide by applicable laws and ethics and protect your confidentiality in all cases.

You have the right to request restrictions on personal health care information that I routinely disclose for purposes of treatment and payment. If, in my professional judgment, the restriction you request could be harmful to you (for example, prevent my ability to provide adequate services to you) I will inform you when I cannot agree to any such restriction you may request.

You have the right to an accounting of certain disclosures of your information I have made after April 14, 2003, not including disclosures for treatment, payment or health care operations, and disclosures made to you or disclosures otherwise authorized by you or by state law.

Other than the routine disclosures noted above which are necessary to perform treatment and billing services on your behalf, no information will be released to any other persons or agencies outside of this office without your written authorization except by court order. Before you give me written authorization to respond to any other requests for your health information, satisfy yourself that the information is really needed, that you understand the

information being sent out, and that giving the information will help you. You have the right to approve or refuse the release of information to anyone, except as provided by law.

EXCEPTIONS to the above information release procedures are:

1. Imminent Danger to Self: In cases of threatened suicide and if, in my professional judgment, your health and safety are at risk, I may contact at least one concerned person and/or the appropriate police agency to intervene and for evaluation.
2. Imminent Danger to others.
3. Grave disability from a mental illness.
4. When I have knowledge of, or reasonable cause to believe, that a child or elder/vulnerable adult is being neglected or physically or sexually abused, in which case state law requires that such information be reported.
5. Reporting of alleged practitioner sexual misconduct.

RIGHT TO READ YOUR OWN RECORDS AND TO SUBMIT AN AMENDMENT
You have the right to inspect and request a copy of your own records (paper or electronic). All requests must be made in writing. I will assist you in understanding your records by being available to answer questions and to explain the meaning of technical terminology. I welcome your informing me of any inaccuracies of information in your file. You have the right to put in writing an amendment to the information in your file, which I will keep in your file.

RIGHT TO KNOW HOW LONG I WILL RETAIN YOUR INACTIVE RECORDS
After you complete services, your record will be retained for seven years. At the end of seven years, the record will be entirely destroyed, leaving only the name of the client and date of record destruction. The time period begins from the date of the last visit. (Or for minors, from the date they reach 18.) Should I provide you with any further direct contact services, the counting period will begin again after conclusion of the new service.

RIGHT TO ACCOUNTING OF DISCLOSURES
Upon written request, you have the right to obtain an accounting of certain disclosures of your personal health care information, excluding those that are necessary to conduct your counseling and payment services as described above and excluding disclosures I have made to you or disclosures you have otherwise authorized.

RIGHT TO DETERMINE ALTERNATIVE COMMUNICATIONS
You may request and I will accommodate any reasonable request for you to receive personal health care information from me by alternative means of communication or at alternative locations. For example, in order to protect your privacy, please inform me to what address you prefer that I mail billing statements or copies of records or letters and what telephone number you prefer I use.

RIGHT NOT TO BE DISCRIMINATED AGAINST
You have the right not to be discriminated against in the provision of professional services on the basis of race, age, gender, ethnic origin, disabilities creed, or sexual orientation.

RIGHT TO KNOW MY QUALIFICATIONS

You are entitled to ask me what my training is, where I received it, if I am licensed or certified, my professional competencies, experience, education, biases or attitudes, and any other relevant information that may be important to you in the provision of services. You have the right to expect that I have met the minimum qualifications of training and experience required by state law and to examine public records maintained by the Colorado Department of Regulatory Agencies and the State Board of Registered Psychotherapists which are the licensure boards that regulate my practice.

My professional competencies include the following: child, adolescent, and adult psychotherapy; couples and family psychotherapy; and group psychotherapy.

RIGHT TO BE INFORMED
You have the right to be informed of my assessment of your problem in language you understand and to know available counseling alternatives. You also have the right to understand the purpose of the professional services I recommend, including an estimate of the number of counseling or consultation sessions, the length of time involved, the cost of the services, the method of counseling, and the expected outcomes of counseling. You have the right and responsibility to help me develop your own counseling plan. If you are considering medication or other remedies, you have the right to be informed by your physician or other health care professional of treatment alternatives, action of the medication or remedies, and possible side effects.

RIGHT TO REFUSE SERVICES
You have the right to consent to or refuse recommended services. I can provide services to you without consent only if there is an emergency and in my opinion failure to act immediately would jeopardize your health. In such emergency cases, I will make reasonable efforts to involve a close relative or friend prior to providing emergency services. No audio or video recording of a treatment session can be made without your written permission.

RIGHT TO VOICE GRIEVANCES
You have the right to voice grievances and request changes in your counseling plan without restraint, interference, coercion, discrimination or reprisal. I encourage you to share any concerns you may have with me directly at the above number, including if you believe your privacy rights have been violated. You also have the right to file a complaint about my services to the Colorado Department of Regulatory Agencies. You may do this online at https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

RIGHT NOT TO BE SUBJECTED TO HARASSMENT
You have the right to not be subjected to harassment—sexual, physical or verbal.

RIGHTS OF ADULTS JUDGED NOT ABLE TO GIVE INFORMED CONSENT
For adults judged not able to give informed consent, the same policy as that for minors (see above) applies regarding permission for services and requests that records be withheld.

REFERRAL RIGHTS
You have the right not to be referred or terminated without explanation and notice. You have the right to active assistance from me in referring you to other appropriate services.

ELECTRONIC COMMUNICATION
I recognize that various forms of electronic communication are common place in our society and that many people find them convenient ways to schedule appointments or ask quick questions.

If you choose to send me an email, a text message, or some other form of electronic communication, I cannot guarantee the security or confidentiality of that medium of communication. It is requested that email and text messaging be used only for scheduling purposes. As with phone calls, I will return your message as soon as possible or by the next business day, and it is your responsibility to take care of yourself until we are able to talk, seeking emergency room care as needed. I will not have therapeutic conversations via electronic communication and will direct such conversations to either a phone or in-person based appointment.

Initial below indicating your consent to any of the following forms of electronic communication. By checking the box, you indicate your awareness that these forms of communication are not secure and therefore their confidentiality cannot be guaranteed by this therapist.

_____ Email to schedule appointments
_____ Text message to schedule appointments
_____ Email response to message originated by client
_____ Text message response to text originated by client
_____ Personalized voicemail messages may be left on my home/cell/work phone:
(_____)_____-_____
_____ None – I do not consent to any form of electronic communication beyond non-disclosing voicemails left at the number on my intake form and will not utilize electronic communication to engage this therapist.

SOCIAL MEDIA

Maintaining a professional relationship is of high personal and ethical importance to me as your counselor. As such, I ask that you not connect with me via social media (i.e. Facebook, Twitter, Instagram, etc.). If you do seek such a connection, or attempt to communicate through such mediums, I will delete the request. Any forms of social media interaction will be prohibited for at least two years after the termination of our therapeutic relationship. This is not meant to be rude or uncaring, but is to protect our professional relationship and maintain your confidentiality as my client.

YOUR RESPONSIBILITIES

As a client, you have responsibilities as well as rights. You can help yourself by being responsible in the following ways:

TO BE HONEST
You are responsible for being honest and direct about everything that relates to you as a client. Please tell me exactly how you feel about the things that are happening to you in your life.

TO UNDERSTAND YOUR PLAN
You are responsible for understanding your counseling plan to your own satisfaction. If you do not understand, ask me. Be sure you do understand since this is important for the success of the treatment plan.

TO FOLLOW THE TREATMENT PLAN
It is your responsibility to discuss with me whether or not you think you can and/or want to follow a certain counseling plan.

TO KEEP APPOINTMENTS
You are responsible for keeping appointments. If you cannot keep an appointment, notify me as soon as possible so that another client can be seen. In any case, you will be charged for appointments when canceled with less than 24 hours' notice.

TO KNOW YOUR FEE
I am willing to discuss my fees with you and to provide a clear understanding for you of the costs of all associated services.

TO KEEP ME INFORMED
So that I may contact you whenever necessary, I will rely upon you to notify me of any changes in your name, address, and home or work phone numbers.

YOUR THERAPIST'S RIGHTS AND RESPONSIBILITIES

I have the responsibility to provide care appropriate to your situation, as determined by prevailing community standards. To accomplish this goal, I also have certain rights, including:

1. The right to information needed to provide appropriate care.
2. The right to be reimbursed, as agreed, for services provided.
3. The right to provide services in an atmosphere free of verbal, physical, or sexual harassment.
4. The right and ethical obligation to refuse to provide services which are not indicated.
5. The right to change the terms of this notice at any time, with the understanding I will inform my clients of any changes.

EMERGENCY PROCEDURES

Should you feel that your situation requires immediate attention, I am available to return your phone calls from 9:00 am to 5:00 pm, Monday through Friday. You may leave a message on my voice messaging service. I check my messages throughout the day, but not in the evenings or on weekends.
I can be reached by phone at 720-608-1777 or by email at shawn@sevenbranchescounseling.com

If you feel that you are in a crisis and need to talk to me immediately at night, during the weekend, or over a holiday, and I am not immediately available, you may call your local crisis intervention center. If you do speak with me, you may be billed at my current hourly rate for individual therapy for the time I spend with you on the phone. You should be advised that your insurance company might not reimburse you for the telephone consultation charge.

APPOINTMENTS

I normally view the first 1 to 2 sessions as a time to get to know one another. Together we can both decide if I am the best person to provide the services you need in order to meet your therapeutic goals. I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more/less frequent as we both feel is needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, it is required that

you provide more than 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hours' notice, you must pay for the missed session. In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment will still need to end on time and you will be billed for the entire session.

FEE INFORMATION

My fee for one hour (50 minutes) of psychotherapy or counseling, supervision, and consultation services is $100. The fee for couples (marriage/pre-marriage) counseling is $130 per 1.5-hour unit (80 minutes). Introductory sessions are billed at a rate of $50 for one hour (50 minutes). Fees associated with assessments will be disclosed prior to administration and must be paid in advance of the order of the assessment. I will inform you whenever I must raise my fees to keep up with cost of living increases. My fee for any time utilized in a forensic situation is $220 per 1-hour unit. Please note however, under most circumstances, even with client consent, it is usually inappropriate for a therapist to become involved in a client's legal case. This is because engaging in dual roles, as therapist/witness, may be potentially harmful to clients.

Every client receiving services shall be responsible for the full payment of those services. I expect clients to make a payment at each session, or upon receipt of a bill, which is mailed on a monthly basis. Payment for your session should be made directly to me. If at any time you find there are any problems regarding fee payment, or you need to make arrangements for a payment plan, I will be glad to speak to you regarding your concern.

I impose a finance charge of one and one-half percent (1.5%) per month (annual percentage rate of 18%) on all past due accounts. I apply payments to the oldest balance first. No finance charge will be assessed against any billing for services until the charge for such services remains unpaid for 60 days.

There may be circumstances under which I may bill you for my time outside your actual therapy sessions, such as: consultation time between me and other health care professionals, telephone consultations to you, special reports and court evaluation, or communication with your insurance company for prior authorizations for further therapy sessions.

INSURANCE

My payment policy is fee-for-service only. Regretfully, I do not accept payment directly from insurance companies and therefore I am not on any managed care or preferred provider plans. However, my services may be reimbursable and I will provide you with a monthly statement that you may submit to your insurance to obtain out-of-network reimbursement. It is up to you to find out the reimbursement policies of your insurance provider. Insurance companies sometimes require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of you problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.

MEDICAID RECIPIENTS

I am not a Medicaid provider and therefore *cannot* provide treatment to Medicaid recipients, regardless of your method of payment.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such feedback will be taken seriously and with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspect of the therapy and about my specific training and experience. You have the right to expect that, in a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder. Furthermore, you are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. If you are unable to read or write, an oral explanation shall accompany this written copy.

THANK YOU

I appreciate your decision to work with me. If you have any questions at any time during the course of your therapy, please feel free to speak to me.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and agree to its terms. It also serves as an acknowledgment that you agree to pay the fee of $_____.00 per session.

By signing below, I indicate that I have read the preceding information and have received a copy of the HIPAA Notice of Privacy Practices. I understand my rights as a client or as the client's responsible party.

_____ _____

Print Client's Name(s)

_____ _____

#1 Client's or Responsible Party's Signature Date

_____ _____

#2 Client's or Responsible Party's Signature Date

If signed by Responsible Party, please state relationship to client and authority to consent:

_____

_____

_____ _____

Shawn L. Trueman, M.A., LPC, NCC Date