

Janet A. Switzer, M.A., LPC, CAC III
d/b/a
High Mountain Therapy, LLC

PO Box 868
Conifer, CO 80433-0868
(303) 493-1401

Jan Switzer, M.A., LPC, CAC III
Licensed Professional Counselor
Certified Addiction Counselor III

DISCLOSURE STATEMENT

1. Everyone fifteen years or older must sign a disclosure statement. This disclosure statement contains the policies and procedures of the High Mountain Therapy LLC and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law. You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing at any time during psychotherapy.

ABOUT MY CLIENT RIGHTS:

2. The Colorado Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. The agency within DORA that has responsibility specifically is the Mental Health Section, 1560 Broadway, Suite #1370, Denver, CO 80202, (303) 894-7766.

3. Client Rights and important information:

- a. You are entitled to receive information from me about my methods of therapy, the techniques used, the duration of your therapy (if it can be determined), and the 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 psychotherapy), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-7766.
- 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 social worker, a licensed marriage and family therapist, 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 clinical social worker, an unlicensed psychotherapist, 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. However, there are legal exceptions to the general rule of legal confidentiality. These legal 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

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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, such as threats to national security under the federal Patriot Act that will be identified to you as the situations arise during therapy.

Psychotherapy fees and treatment are based on a **45 to 50 minute clinical hour** instead of a 60 minute clock hour.

AS A PSYCHOTHERAPY CLIENT I UNDERSTAND THAT:

7. I understand that court testimony on my/our behalf is charged at a higher rate 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 my psychotherapist(s) to release confidential information in courtroom testimony and written reports to the Court.

8. I understand that there may be times when my psychotherapist(s) 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(s) permission to consult as needed to provide professional services to me as a client.

9. I understand that in marriage and 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.

10. I understand my psychotherapist(s) provides non-emergency psychotherapeutic services by scheduled appointment. If my psychotherapist(s) believe(s) my psychotherapeutic issues are above her or his level of competence, or outside of his or her scope of practice, he or she is legally required to refer, terminate, or consult. If, for any reason, I am unable to contact my psychotherapist(s) by telephone, (303) 493-1401, and I am having a true emergency, I will call 911 or check myself into the nearest hospital emergency room.

11. I understand that I have any questions or would like additional information, I may please feel free to

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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 psychotherapist(s). They will also have to sign separate disclosure statements.

12. I understand that I am legally responsible for payment for my psychotherapy services, if, for any reason, 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. Failure to pay will be a cause for termination of psychotherapy services. Failure to pay any outstanding bills remaining on your account is subject to being turned over to Alpine Credit for collections.

13. 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.

14. CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT

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 psychotherapist(s) to seek consultation with the agency that referred me and/or my minor children, other psychotherapists or professionals as the need arises. I 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. This disclosure statement will be automatically revoked one year after signing in compliance with HIPAA guidelines.

Client Signature

Date

Client Signature

Date

Jan Switzer, M.A. Licensed Professional Counselor, CAC III

Date