

# *The Mindbody Center*

2010 West 120th Ave., #203

Westminster, CO 80234

720-685-7474

## **CLIENT INFORMATION AND DISCLOSURE FORM**

The State of Colorado Department of Regulatory Agencies requires that you be informed of your rights as a client of counseling or psychotherapy services and that you be given information which is designed to protect you:

You have the right to be informed of the degrees and license of the counseling professional that is serving you.

You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate.

The information provided by you during therapy sessions is legally confidential except when the law requires disclosure by the therapist, such as in the case of sexual abuse. If you use an insurance company for payment or your services, that insurance company has rights to your records.

You have the right to see another therapist at any time.

The address of the Mental Health Board of the Department of Regulatory Agency is:

1560 Broadway, Suite 1340

Denver, CO 80202

303-894-7766

Our policies:

- Each session is approximately 50 minutes.
- Your co-pay, or agreed upon payment, is due at the beginning of each session.
- We require 24-hours advanced notice to cancel a session. If a client does not show-up for his/her appointment, he/she will be charge the full fee for the appointment. If the client cancels in less than 24-hours before their appointment, a \$35 fee will be charged. If the session is cancelled due to illness, family crisis, blizzard or car emergency, no fee will be charged. Although we will not charge you for the appointment in that case, please call and let us know if at all possible. Deciding to do something else that day, for example, choosing to work overtime or on a day that was

a planned day off, will not be considered an emergency. If this is a concern for you, please let us know so we can discuss this. We require a Visa or debit card number on your intake to cover these conditions. If we need to use it, we will call you. All information is locked in our confidential filing cabinets.

- Phone calls are \$15 for every 10 minutes. There is no charge for calls less than 10 minutes, whether it is about appointment times or information exchange. There will be a charge for written reports for litigation or evaluative purposes at \$110/hr.
- We have on-call services on evenings and weekends. If this is something you need, please discuss this with your therapist.

Whether you'll be submitting your bill to insurance yourself, or if we will be billing your insurance company directly or if you are private pay, you are solely responsible for the counseling fees incurred.

**Insurance:** It is in your benefit to know the name, type of insurance plan, and your benefits as you are using them to pay your fees for your counseling service. Please communicate that clearly to your counselor. We will then bill according to the information you have given us. If you change the way you want us to bill later, we cannot refund and re-bill. Your bill will be your responsibility whether or not you are expecting your insurance company to pay a certain amount. It pays to be extremely clear with your insurance company on what their financial agreements are with you. In most cases they cannot be specific unless it is an employee Assistance Program. In other cases, your deductible and number of sessions may depend on your diagnosis and this diagnosis will be a part of your medical records.

**Private Pay:** If you are paying by cash, check or Visa and we are not billing your insurance, you are eligible for distance counseling by phone, email, or video-cam for \$30/ 1/2 hr and \$60/hr. This delivery system is not reimbursable by insurance.

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**I have read the above and agree to the policies stated.**

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date