Mile High Hope
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7009 South Potomac Street
Suite 109
Centennial, CO 80112

DISCLOSURE STATEMENT

As a client of psychotherapy and as a consumer, you have certain rights. This form informs you of these rights so that you can feel informed and protected during our work together. I strongly believe that open communication is key to the therapeutic process and your health; therefore I will explain my credentials, therapeutic model and my expectations for a cooperative working agreement. Please feel free to ask questions about any of the following information.

Therapist's Training

I. Graduated from the University of Denver in 2002 with a Masters Degree in Social Work.

II. Graduated from University of Colorado in 2000 with a Bachelors Degree in Social Work.

III. Everyone fifteen or older must sign a disclosure statement. This disclosure statement contains the policies and procedures of Mile High Hope and is HIPPA 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.

IV. 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 1350, Denver, CO 80202, (303) 894-7800.

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 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) 894-7800.

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, 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 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, which will be identified to you as the situations arise during therapy.

AS A PSYCHOTHERAPY CLIENT I UNDERSTAND THAT…

4. 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, cross examination time and courtroom waiting time. Signing this disclosure statement gives permission for my psychotherapist to release confidential information with my permission in courtroom testimony and written reports to the Court.

5. 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. I also understand that my psychotherapist may seek supervision and could discuss my case with her supervisor. The supervisor also withholds confidentiality standards and is interested in the best practice for the client.

6. 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.

7. 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) 765-1677, and I are having a true emergency; I will call 911 or check myself into the nearest hospital emergency room.

8. I understand that I have any questions or would like additional information; I may feel free to 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/close friends in psychotherapy when deemed necessary by my psychotherapist(s) or myself. They may also have to sign separate disclosure statements.

9. Mile High Hope does not take insurance. I understand that I am legally responsible for payment for my psychotherapy services, if, for any reason, a third-party payer does not compensate my therapist. I also understand that signing this form gives permission to my psychotherapist to communicate to a third-party payer or anyone connected to my psychotherapy funding source. Failure to pay will be a cause for termination of psychotherapy services.

10. 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 my 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.

11. As a client of Jennifer Finger I may choose to participate in some or most sessions over the phone or via Skype/Facetime as an option. I realize that if I choose this option I have to make a payment before service is given due to the unique nature of phone or Internet counseling. I realize that no phone line is absolutely secure; therefore Jennifer Finger is not responsible if information is heard through another cell phone pick up.

12. I understand that texting and emails are not confidential or secure. Jennifer Finger cannot be held liable if communication is tampered with if this is your chosen way to communicate. Texts may not be answered or acknowledged unless it is regarding scheduling.

CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, 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 also consent to me, my 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, Mile High Hope (Jennifer

Finger). This disclosure statement will be automatically revoked one year after signing in compliance with HIPAA guidelines. By initialing all the above sections you are saying that you read and understand each section listed above.

CLIENT'S SIGNATURE _____ DATE

PSYCHOTHERAPIST'S SIGNATURE _____ DATE