Disclosure Statement & Policies

This Disclosure Statement & Policies contains important information. Please review it carefully. Everyone fifteen (15) years and older must sign this disclosure. A parent or legal guardian with the authority to consent to mental health services for their minor child/ren, must sign this disclosure on behalf of their minor child under the age of fifteen (15) years old. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal Regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. Envision Counseling Clinic (ECC) is located at 734 Wilcox St., Suite 202, Castle Rock, CO 80104. Your therapist is: Timi Schuessler. Her credentials are:

   Master of Arts Degree in Counseling, Colorado Christian University 2008
   Licensed Professional Counselor, Colorado, #6491

2. The Colorado Department of Regulatory Agencies (“DORA”), Division of Professions and Occupations (“DOPO”) has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291; DORA_MentalHealthBoard@state.co.us. The State Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through Envision Counseling Clinic’s internal process.

3. The Levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination. There are different mental health professionals that are available to you. Each type of professional has different training requirements. They are listed below to help you decide which professional will be of most assistance to you.

   - **Registered psychotherapist** is authorized by state law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any educational or testing requirements to obtain a registration from the state, but they are required to pass a jurisprudence take-home examination.
   - **Certified Addiction Counselor I** must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
   - **Certified Addiction Counselor II** must complete additional required training hours and 2,000 hours of supervised experience.
   - **Certified Addiction Counselor III** must have a bachelor’s degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
   - **Licensed Addiction Counselor** must have a clinical master’s degree and meet the CAC III requirements.
   - **Licensed Social Worker** must hold a master’s degree in social work.
   - **Psychologist Candidate, Marriage and Family Therapist Candidate, and Licensed Professional Counselor Candidate** must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
• Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and Licensed Professional Counselor must hold a master’s degree in their profession and have two years of post-master’s supervision.
• Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

By signing below, you agree to abide by and understand the following policies of Envision Counseling Clinic:

CLIENT RIGHTS AND IMPORTANT INFORMATION

1. You are entitled to receive information about methods of therapy, techniques used, the duration of therapy (if it can be determined), and your therapist’s Fee Structure. If you have any questions or want additional information, please address them with your primary therapist. Your therapist is trained in a variety of therapy methods and techniques. In addition, your therapist has education, training and experience in providing therapy that integrates Christian faith with the practice of psychology. Integration looks different for each client, ranging from a desire that the therapist simply understand the values the client holds, to incorporating scripture or prayer into therapy, and many options in between. If you desire to incorporate certain Christian faith-based practices into your therapy, please let your therapist know. Otherwise, your therapist will provide therapy that does not incorporate faith-based practices. It is completely up to the client to choose the type of therapy desired. Both types of therapy (faith-based and not faith-based) are provided with clinical and scientific expertise. Although your therapist may use a treatment approach stemming from a Christian belief or perspective, your therapist will never impose her beliefs, values, behaviors, and/or attitudes on you.

2. Fees:
   • The following is the Fee Schedule for Timi Schuessler:
     o Therapy: $125.00 per 55-minute session
   • It is ECC’s policy to collect all fees at the time of service, unless otherwise mutually agreed to in writing. In addition, ECC requests that you fill out a “Credit Card Authorization” form.
   • Should you cancel within 24 hours of your appointment (“late cancel”) or fail to show up for my scheduled appointment without notice (“no-show”), excluding emergency situations, ECC has a right to charge your credit card on file, or your account the full amount of the session ($125).
   • All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. You will incur a monthly interest rate of 1.67% (APR of 20%) if your account becomes past due.
   • If your account is past due, please be advised that ECC may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. Should this occur, ECC will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. ECC will not disclose more information than necessary to collect the past due account. ECC will notify you of its intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.
   • If a check is returned and/or credit card declined for any reason, including but not limited to insufficient funds, you will be charged an additional $35.00.
   • Telephone calls, written consultations, emails, and telephone consultations of 10 minutes or more may be charged a pro-rated amount based upon the rate above, with a prorated minimum rate of 15 minutes.
   • If you request legal services on your behalf, those legal services are charged at a higher
rate. Legal services include but are not limited to: testimony related matters like case research, correspondence with PREs and other court-related personnel, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $250 per hour.

- Envision Counseling does not accept insurance and does not submit any reimbursements to insurance companies. ECC can provide you with a super bill but it is solely your responsibility to submit that bill to your insurance company.

- You are legally responsible for payment for your therapy services. If for any reason, your insurance company, HMO, third-party payor, etc. does not compensate your therapist, you understand that you remain solely responsible for payment. You also understand that signing this form gives permission to your therapist to communicate with your insurance company, HMO, third-party payor, collections agency or anyone connected to your therapy funding source regarding the financial aspects of your therapy. You may request a copy of any report ECC submits to a third-party payor on your behalf. Failure to pay will be a cause for termination of therapy services. Should you require after hours emergency care, you are solely responsible for all costs arising from such care.

3. You may seek a second opinion from any other therapist or terminate therapy at any time. Your primary therapist can provide you with referrals in the community.

4. In a professional relationship, sexual intimacy between a therapist and client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that regulates the therapist located above.

5. Confidentiality: Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, LPC Candidates, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, or a Registered Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client’s consent.

- Information disclosed to the above listed mental health practitioners 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.

- **There are exceptions to this general rule of legal confidentiality.** These exceptions are listed in the Colorado statutes, C.R.S. § 12-43-218. These exceptions include any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. Additional exceptions include: your therapist is required to report child abuse or neglect situations; is required to report the abuse or exploitation of an at-risk elder or the imminent risk of abuse or exploitation; if she determines that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, she is required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened, and may take immediate action to protect you or others from harm; if you become gravely disabled, your primary therapist is required to report this to the appropriate authorities; or if you confess to an ongoing felony or other serious crime, your primary therapist may be required to report that information to the appropriate law enforcement agency. Your primary therapist also may disclose confidential information in the course of supervision or consultation in accordance with ECC’s policies and procedures, in the investigation of a complaint or civil suit filed against your primary therapist or ECC, or if your primary therapist or ECC is ordered by a court of competent jurisdiction to disclose such information. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.
Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, ECC and your primary therapist cannot guarantee those communications will be kept confidential; there are limitations that exist. Please review and fill out ECC’s Consent for Communication of Protected Health Information by Non-Secure Transmissions for more information.

6. Telephone Calls:
   • Some clients find it helpful to leave a check-in message which is a voicemail letting their primary therapist know what they are experiencing in that moment. These messages should be under two minutes and state three things: (1) A brief description of what is happening, (2) what you are feeling and thinking, and (3) what tools and/or techniques you are using to deal with the situation. Your primary therapist will take note of the message and will address your experience at the next scheduled therapy session. These “check-in” messages should not be used in case of an emergency.
   • If you request that your primary therapist call you back, please know that the return phone calls are limited to ten minutes. Your primary therapist may provide you with tools and/or techniques to assist you until your next scheduled counseling session.
   • Your therapist checks messages regularly, and strives to return your call within 24 hours or by the end of the following business day. Your therapist is not available to return calls, emails, or texts after hours, on weekends, or holidays.
   • I understand my primary therapist provides non-emergency therapeutic services by scheduled appointment only. If, for any reason, I am unable to contact my primary therapist by the telephone number she provided me, 720-935-2663, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, call Colorado’s Crisis Hotline (844) 493-8255, or call Denver Springs Mental Health at 720-643-4300 where you can receive a free 24-hour/seven day per week confidential assessment. Your primary therapist is unaffiliated with Denver Springs. ECC does not provide after-hours service without an appointment. If I must seek after hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due.
   • Please limit email and text communications to administrative purposes only, such as scheduling matters. Do not use email or text communications to address therapeutic matters.

7. Records: All records about your counseling will be maintained in a secure place, with only authorized persons having access to them. At the completion of counseling, these records will be kept for the minimum time as required by ethics codes and laws, then destroyed. Your records may not be maintained after seven years.
   • ECC may keep and store records for each client electronically on its laptops, desktop computers, and/or some mobile devises. In order to maintain security and protect the record, ECC employs the use of firewalls, antivirus software, passwords, and encryption methods to protect computers and/or mobile devices from unauthorized access. ECC can also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged. Passwords are changed regularly as well.
   • ECC also uses the backup and online electronic storage system “TheraNest.com.” Use of this type of electronic online storage helps prevent the loss or damage of records. These backups are stored on computers which are connected to the internet. In order to maintain security of these backups, ECC has employed the following procedures:
     o Entered into a HIPAA Business Associates Agreement with TheraNest and Amazon Web Services. Because of this Agreement, the TheraNest is obligated by federal law to protect these backups from unauthorized use or disclosure.
     o The computers on which these backups are stored are kept in secure data centers, where various security measures are used to maintain the protection
of the computers from physical access by unauthorized persons.

- The TheraNest and Amazon Web Services employs various security measures to maintain the protection of these backups from unauthorized use or disclosure, such as using SSL encryption, built-in firewalls, multi-factor authentication, among other security measures.
- The data centers in which the information is stored is staffed 24 hours a day by trained security guards.

- It may be necessary for other individuals to have access to these backups, such as TheraNest’s or Amazon Web Services’ workforce members, in order to maintain the system itself, and federal law protecting the backups extends to these workforce members. If you have any questions about the security measures ECC employs, please ask.

8. **Extraordinary Events:** In the case that your primary therapist becomes disabled, dies, or is away on an extended leave of absence (hereinafter “extraordinary event,”) the other Mental Health Professional listed below will have access to your primary therapist’s client files. If your primary therapist is unable to contact you prior to the extraordinary event occurring, the other Mental Health Professional will contact you. Please let your primary therapist know if you are not comfortable with the above listed Mental Health Professional and your primary therapist will discuss possible alternatives.

NAME: Veronica Johnson  
ADDRESS: 734 Wilcox St., Suite 202, Castle Rock, CO 80104  
TEL: 720-935-2663  
CREDENTIAL: Licensed Psychologist

The purpose of designating another Mental Health Professional to have access to your records in the case of an extraordinary event is to continue your care and treatment with the least amount of disruption as possible. You are not required to use designated Mental Health Professional for therapy services, but designated Mental Health Professional can offer you referrals and transfer your client record, if requested.

**I, the CLIENT, agree:**

1. I understand that if I initiate communication via electronic means that I have not specifically consented to in ECC’s Consent for Communication of Protected Health Information by Non-Secure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.

2. I understand that there may be times when my primary therapist may need to consult with a colleague or another professional, like an attorney or supervisor, about issues raised by me in therapy to provide professional services to me as a client. My confidentiality is still protected during consultation by my primary therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. I understand that I will need to sign a separate Release of Information for any discussion or disclosure of my protected health information to another professional besides an attorney.

3. I understand that communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. I understand that should I want Teletherapy (such as therapy over videoconference or telephone), I will discuss my request with my primary therapist. I understand that it is in my primary therapist’s sole discretion whether to accommodate my request for Teletherapy.
4. I understand that ECC, or any therapist at ECC, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be rejected in order to maintain professional boundaries. I understand that ECC has, or may have, a business social media account page. I understand that there is no requirement that I “like” or “follow” ECC’s page. I understand that should I “like” or choose to “follow” its page that others will see my name associated with “liking” or “following” Envision’s business social media page. I understand that this applies to any comments that I post on the page as well. I understand that any comments I post regarding therapeutic work between my therapist and I, will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through in accordance with the Consent for Communication of Protected Health Information by Non-Secure Transmissions and not through social media.

5. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my primary therapist and address those questions.

6. If my primary therapist believes, in her sole determination, my therapeutic issues are above her level of competence, or outside of her scope of practice, she is legally required to refer, terminate, or consult.

7. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date. I understand that I have received ECC’s Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information, and acknowledge receipt of the policy.

8. I understand that any inclusion of third-parties in my therapy will required them to sign a separate Consent for Third-Party Participation Agreement or they may have to sign a separate disclosure statement in order to participate in therapy.

9. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with ECC or my primary therapist, my treatment will be considered “terminated.” I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with my primary therapist. Ability to resume therapy after sixty (60) days will depend upon my primary therapist’s availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. I may be asked to provide additional information to update my client record. I understand “discontinuing therapy” means that I have not had a session with my primary therapist for at least sixty (60) days.

10. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

11. Because of the nature of therapy, I understand that my therapeutic relationship has to be
different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of psychotherapist and client. This means that your primary therapist cannot be your friend. ECC or your primary therapist cannot have any type of business relationship with you other than the counseling relationship (i.e. ECC or your primary therapist cannot hire you, lend to or borrow from you; or trade or barter for services in exchange for counseling). Your primary therapist cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client. Your primary therapist cannot hold the role of counselor to relatives, friends, the relatives of friends, social contacts, or business contacts.

12. I affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services here at ECC or that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15), for whom I am requesting therapy services here at ECC.

13. I understand that it is beyond the scope of my therapist’s practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

14. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that ECC is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by Timi Schuessler, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask Timi Schuessler.

___________________________________________  ______________________
Client Signature & Printed Name                        Date

_________________________________________________  ______________________
Parent/Legal Guardian (if applicable) & Relationship to Client Date

_________________________________________________  ______________________
Timi Schuessler, MA, LPC                             Date