Disclosure Statement and Consent to Treatment

This form contains the information necessary for you to understand and consent to before beginning counseling. Please take the time to read through thoroughly, and feel free to bring up any questions you may have.

Registrations
Licensed Professional Counselor #796, State of Colorado
The practice of licensed or registered persons in the field of psychotherapy is regulated in Colorado by the Mental Health Licensing Section of the Division of Registrations. The Department of Regulatory Agencies can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

Client Rights and Important Information
You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. This information is available on my website: www.garyajohnsonllc.com. You can seek a second opinion from another therapist or terminate therapy at any time. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. Unless you grant me permission to do by written permission, I will not inform anyone that you are receiving therapy, nor disclose the content of our sessions. There are certain legal exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes as well as other exceptions in Colorado and Federal law.

The following are conditions under which Gary Johnson may be legally required to break confidentiality:

- If there is reasonable suspicion that you pose a serious physical danger to yourself or others.
- If you disclose that you or another person has physically or sexually abused or molested a child or an incompetent or disabled person.
- If you disclose that a child or an incompetent or disabled person is suffering because of neglect.
- If there is reasonable suspicion of any incident of elder abuse or neglect.
- If there is reasonable suspicion that you pose a serious physical danger to yourself or others.
- If there is any suspected threat to national security.

If a legal exception arises during therapy, if feasible, you will be informed accordingly. Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist 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.

When I do couples therapy, my allegiance is to the couple and I do not "hold secrets" for either partner. During the course of couples therapy I typically meet with each partner for an individual session(s). The individual session is part of the couples therapy, and information disclosed during individual sessions may be brought into the couple's sessions when relevant to the couple's therapy. If an individual chooses to share private information with me vital to the couples therapy, I may encourage and guide the disclosure of that information. If the individual refuses this disclosure within the couple's session, I may determine that it is necessary to discontinue counseling with the couple. This policy is intended to maintain the integrity of the counseling relationship.

Colorado law requires that any individual seeking mental health services must be informed that sexual intimacy between a client and therapist is never appropriate and should be reported to the governing board immediately.

Financial Agreement
By entering into a professional psychotherapy relationship with Gary Johnson, you are also entering into a financial arrangement. Payment for services rendered is the sole responsibility of the client (or responsibility party as signed below), unless otherwise agreed upon in writing by Gary Johnson and the client(s).

Unless otherwise arranged, psychotherapy sessions will be conducted face-to-face and will last 50-60 minutes. The standard fee per session is $120, and will be due at the time of service. Any other fee must be agreed upon in writing. Sessions lasting over 60 minutes in length may be subject to additional service fees. Additionally, phone calls lasting over 15 minutes may incur charges. If a report, letter, or consultation with an outside party is requested, you may be billed for any time needed to prepare documentation or conduct an in-person or phone consultation. The standard service fee will apply.

Psychological assessments will be billed at the following: _____ for _____.

Clients are responsible for payment at the time services are rendered. The preferred form of payment is personal check. The following forms of payment are also accepted: Visa, MasterCard, and Discovery cards, including HSA/FSA accounts. A $35 admin fee is assessed on all checks that are returned for insufficient funds.

Cancellation Policy
My counseling sessions are 50-60 minutes, and the time is reserved for you. I realize that arranging appointment times in a busy schedule is often difficult. If you need to change or cancel an appointment, please do so at least 24 hours in advance by calling 720 545 4073 and leaving a message for me. If notification is not given, the full fee will be charged for the missed session. Please note that I do not carry a pager, nor am I generally available for emergency situations after normal business hours. If you need this level of professional care, please make me aware of this now and I will give you appropriate referrals. I check my voicemail at the end of the workday for messages. I use email for scheduling appointments, but not for counseling of any kind.

Insurance
I do not directly bill through any insurance or medical plan; however, upon request, I can provide insurance-ready statements at the end of each month detailing payments you have made to my practice. These statements can be used to initiate the reimbursement process privately through your insurance company if you choose.

Consent to Treatment
I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party. By signing this document, I voluntarily authorize and consent to mental health and/or consultative services with Gary A Johnson in accordance with the information contained within.

_____ _____
Print Client's Name(s)

_____ _____ _____
Client's or Responsible Party's Signature Date

Receipt of Notice of Privacy Practices
I acknowledge that at the time of receiving and signing this form, I have also received the Notice of Privacy Practices of Gary A Johnson LLC.

_____ _____ _____
Client or Responsible Party's Signature Date