# Disclosure and Consent to Treat

**Gary A Johnson LLC**
Gary A Johnson, MDiv, DMin
CO Licensed Professional Counselor, #796

4410 Arapahoe, Suite 205
Boulder, CO 80303
Phone/Voicemail: (720) 545-4073

## Regulation of Counseling

The Colorado Department of Regulatory Agencies, Mental Health has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselor, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. Any concerns or complaints about licensed or unlicensed mental health professionals may be addressed to the State Grievance Board, 1560 Broadway Ave, Suite #1350, Denver, CO, 80202, (303) 894-7800.

## Client Rights and Important Information

The Colorado Department of Regulatory Agencies requires that you be provided the following information when seeking counseling services. You are entitled to receive information from your counselor about methods of therapy and the therapeutic techniques used. Please ask for this information if you wish to receive it.

- You are entitled to an estimate of the duration of your therapy, as possible.
- You are entitled to information about my fees and requirements for payment.
- You may seek a second opinion from another mental health professional or terminate therapy at any time.
- Sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the CO Department of Regulatory Agencies, the Division of Registration.

## Confidentiality

The confidentiality of your counseling is protected by law. Generally, as a therapist I cannot disclose this information provided by or to the client without written consent.

There are several exceptions to confidentiality as follows per C.R.S. 12-43-218.

- I am required to report any suspected incident of child abuse or neglect to law enforcement.
- I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened.
- I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder
- I am required to report any suspected threat to national security to federal officials.
- I may be required to disclose treatment information when ordered by a court.

  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) as 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.

**Fees, Payment and Scheduling**

Clients are responsible for payment at the time services are rendered. The preferred form of payment is a 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.

My fees are based on fifty (50) minute sessions. My normal per session fee is $130/hr (individual and couple.) Phone consultations are the patient's responsibility and are billed in 15-minute increments.

Changes or cancellations must be made at least 24 hours in advance of any workday. Changes or cancellations received less than 24 hours in advance may be charged a regular per-session rate. Any missed appointment with no call received will be charged the regular per-session rate.

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**

While many insurance policies provide partial coverage for mental health services, I do not accept insurance nor do I directly bill through any insurance or medical plan. However, upon request, I can provide you with a coded invoice that can be used to initiate a possible reimbursement process privately through your insurance company if you choose.

**Supervision**

My commitment to the highest quality of care to clients requires that I periodically participate in professional supervision, peer consultations and group consultations. The confidentiality of clients is protected in all these clinical forums. Also, I may be required to make video or audio recordings of sessions for supervision and/or consultations, in which event you will be asked to sign a consent form to approve such recording.

**Client Agreement and Consent to Treatment**

I authorize treatment of the person(s) named below and agree to pay all fees for such 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 consultation services with Gary A Johnson in accordance with the information contained within.

| | |
|---|---|
| _____ | _____ |
| Name | Spouse's/Partner's Name |
| _____ | _____ |
| Signature | Signature of Spouse/Partner |
| _____ | _____ |
| Date | Date |

Address: _____

_____