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Disclosure Statement, Client Rights and Agreement for Services

Welcome to my practice. This statement is provided so that you are aware of your rights as a psychotherapy client, and so that you understand the services I provide. I ask that you please bring up any questions or concerns you may have about what is written here. Once you have fully understood the following, I will ask you to sign this, and a copy will be given to you.

Education and Credentials:

BA, Psychology – University of Colorado

MA, Counseling – Denver Seminary

National Certified Counselor (NCC)

Licensed Professional Counselor (LPC)

EMDR Level II, Attachment and EMDR Certification

6 month Training and Mentorship, Somatic Training Institute

Regulation of Psychotherapy Practices: The Colorado Department of Regulatory Agencies regulates the practice of licensed and unlicensed individuals who practice psychotherapy. Questions or complaints regarding the practice of mental health therapy may be directed to this department's Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202, (303-894-7800). As to the regulatory requirements applicable to mental health professionals, a Licensed Professional Counselor must hold a Masters degree in their profession and have 2 years of post-masters supervision.

Client Rights and Important Information:

You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask me at any time if you would like to review this information.

You can seek a second opinion from another therapist or terminate therapy at any time.

In a client-therapist relationship, sexual intimacy is never appropriate. If it occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section (contact information listed above).

Confidentiality:

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential and cannot be released without the client's consent. There are several **exceptions** to this general rule of confidentiality that are required by law. I am required to report:

- Any information disclosed to me about suspected incidents of current or past child abuse or neglect. I will also report suspected abuse or neglect of dependent elderly persons.
- If a client becomes a danger to themselves or others, or is incapable of self-care.
- Any suspected threat to national security or to federal officials.

I may be required to disclose treatment information when directly ordered by a court of law, or in the case of delinquency or criminal proceedings (except as provided in C.R.S. 13-90-107). You can read about exceptions to confidentiality in the Colorado statutes (C.R.S. 12-43-218).

Fees:

Counseling sessions are 60 minute in length, and are $100.00 a session. Some EMDR sessions and couple/family sessions are 90 minutes and $150.00. Payment is due at the beginning of each session, by check or cash. Checks are made out to Valerie Grant, Ltd. **You will be responsible for paying the full price of sessions that are missed or cancelled less than 24 hours in advance**, as time reserved for you is time unavailable to schedule.

I am an independent practitioner. Although I share office and suite space with other practitioners, we are not practicing in association with one another and we do not supervise each other's work.

Phone calls:

I try to return phone calls within 24-hours. Phone calls longer than 15 minutes will be billed by 30 minute segments, $50.00 per 30 minutes.

My practice *is not a crisis practice*. I provide non-emergency psychotherapeutic services by appointment. If you have a life threatening emergency, you need to call the National Suicide Hotline (800)273-8255, or the police (911), or go immediately to the nearest hospital waiting room.

Client Acknowledgement:

I have read the preceding information and understand my rights and responsibilities as a client/patient.

Client printed name:_____

Client signature:_____Date:_____

Therapist Signature _____ Date_____