Cary Dodson, MA, LPCC
CONSENT for Therapeutic Services
Individual and Family Counseling
1019 37th Avenue Court, #2
Greeley, CO 80634

COLORADO CENTER FOR TRAUMA & ATTACHMENT
DISCLOSURE STATEMENT: Client Rights and Responsibilities

LPCC.0022019
Under the Supervision of Andrea Shindle, MA, LPC, NCC
LPC.0014992

Degrees

Adams State University, Alamosa, CO
Master of Arts in Clinical Counseling
Colorado State University, Fort Collins, CO
Master of Music in Music Education
Florida State University, Tallahassee, FL
Master of Music in Music Performance
Portland State University, Portland, OR
Bachelor of Music in Music Performance

Memberships:
American Counseling Association
EMDR International Association (EMDRIA)

The practice of both licensed and unlicensed psychotherapists is regulated by the Department of Regulatory Agencies under CRS 12.43.214 (1)(c). Questions or complaints may be addressed to: Department of Regulatory Agencies Colorado Mental Health Section Denver, CO 80202 (303) 894-7766. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202 (303)894-7800.

•A Licensed Professional Counselor must hold the necessary licensing degree, a master's degree in their profession, and must complete 2 years of post master's supervision and 2000 hours of direct client contact in Colorado.

_____ 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. **The self-pay fee per session is $125.00 for service codes 90791 (intake), 90847 (family counseling) and 90837 (individual session). A third party billing person, MBS, will provide client statements as well as billing to the insurances in which we contract. We do our best in providing up to date information regarding services covered by insurance, however, by signing this consent, you are agreeing to pay any balance that is not covered by your insurance policy. If you have billing questions, please contact Becky at 970-522-2750. The cost estimate for payment is only a Good Faith Estimate. Unpaid balances will be sent to a third-party collection agency if there is no attempt by the client to make payment on an overdue balance. This is to comply with the No Surprises Act.**

_____ Please be advised that information provided by an insurance benefit check confirms that you have active insurance and gives an estimate of what the responsibility may be. The insurance portals give us limited information. We strongly urge you to check with your insurance as well. We do not accept Medicaid.

The self-pay fee will be pro-rated per quarter hour for telephone consultations, report writing, or time spent reviewing documents. Appointments that are not cancelled 24 hours in advance will be billed to you at the regular fee of $125.00, unless there is an emergency. Court Expert Testimony as well as report writing, professional consultation and research will be billed at $250.00 per hour.

_____ I am not able to provide 24 hour care as a private clinician. In the event of an emergency, please contact 24 hour emergency care with North Range Behavioral Health at (970) 347-2120 or 988 or go to your local emergency room. After you have contacted 24 hour emergency care, please contact me and leave a message.

You have the right to seek a second opinion from another therapist or terminate therapy at any time. We will end therapy when goals have been met. If I feel that I cannot be helpful to you or there is minimal progress, I will make a referral to another clinician. I understand that the therapist may consult with other therapists in the Center in order to provide ethical and best practice methods.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers or certifies the licensee, registrant or certificate holder.

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. There are exceptions to this confidentiality, some of which are listed in section 12-43218 of the Colorado Revised Statutes and the HIPAA Notice of Privacy Practices you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse, threat of harm to self or others to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. A client's records may not be maintained after seven years pursuant to §12-245-226(1)(a)(II)(A), C.R.S.

____ I understand that my therapist is an independent contractor with the Colorado Center for Trauma and Attachment.

____ I consent to receiving and sending my information via email and text message. I understand that the therapist uses a laptop and email that is password protected however does not provide encryption.

I have been informed of my therapist's degrees, credentials, and licenses. I have also read the preceding information and understand my rights and responsibilities as a client. By signing below, I am stating that I have read the preceding information, it has been provided verbally, and I understand and agree to all the conditions listed above. By signing this consent, I understand that I am responsible for charges that are not covered by insurance. I am consenting to treatment and have legal authorization for myself or the client if under the age of 12.

_____

Print Client's name

x_____ x_____

Signature of Client or Legal Representative Date

_____ x _____

Counselor's Signature Date

If signed by Responsible Party, please print name and state relationship to client and authority to consent:

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