CONSENT FOR SERVICES

I voluntarily apply for and consent to receiving psychotherapeutic services, either for myself or for my dependent:

(First Individual Receiving Services)
(name) _____________________________, (relationship) __________________;

(Additional Individuals Receiving Services in conjunction with the above named)
(name) _____________________________, (relationship) __________________;
(name) _____________________________, (relationship) __________________;
(name) _____________________________, (relationship) __________________;
(name) _____________________________, (relationship) __________________;

Psychotherapeutic services may include evaluation, assessment, diagnosis, and treatment by the psychotherapist named in my Client Disclosure Statement. Additionally, I am aware that psychotherapeutic, counseling, and/or addictions/recovery services are not based on an exact science and that the type(s) of treatment I receive will depend primarily on my own needs and abilities. I understand that, as such, I cannot be given any guarantees about the results of any of these services. Further, I also understand that I may withdraw this consent at any time.

- I understand that I am an active participant in the process of establishing, evaluating, and accomplishing my therapeutic goals and demonstrate this by my ability and willingness to communicate my ideas, thoughts, feelings, needs, likes, and dislikes. I understand that by naming and negotiating my needs openly and clearly, and by bringing my full attention and awareness into this process, I am empowered to respect and care for myself.
- The three basic therapeutic agreements expected of me are:
  1) Telling the truth to the best of my ability
  2) Acknowledging my feelings, thoughts, and needs at their fundamental level
  3) Honoring my agreements with my therapist or renegotiating existing ones to meet my needs if my needs change
- I understand that making a commitment to these three basic agreements facilitates and accelerates the creation of an environment that enables me to reach the goals I have established with my therapist. If at any point I do not feel I can continue to commit to these agreements, I will inform my therapist.

DISCLOSURE OF INFORMATION

- I understand that information will only be shared in accordance with HIPAA regulations.
- I understand that any release of verbal, written, and/or electronic information about my therapeutic relationship must occur with my written consent, with a few exceptions. These exceptions include the possibility of imminent danger to me, imminent danger to others, or if I am not able to safely take care of my basic needs because of a disabling condition.
- I understand that some aspects of my therapeutic relationship will be shared with other clinical staff on a need to know basis. These situations include, but are not limited to, clinical supervision, mentoring, back-up coverage, invoicing, and scheduling.
- I understand that that my signature for consent to release information must be directed to an identified individual for an identified purpose for an identified period of time.
- I understand that if I am a parent or guardian of a minor age child or children, I must sign an acknowledgement of the need for mandatory disclosure of abuse or neglect of any minor age child or children.
- I understand that information about me as the client can be electronically transferred for the purposes of filing insurance claims or seeking professional consultation.

- I understand that providing an email address for my therapist to use when contacting me presumes my understanding that this form of communication cannot be guaranteed to be confidential and I release him or her from any unintentional liability that this may incur.
- I understand that providing a cellular telephone number for my therapist to use when calling me presumes my understanding that this form of communication cannot be guaranteed to be confidential and I release him or her from any unintentional liability that this may incur.
- I understand that information may be transferred by facsimile if deemed necessary to expedite services when appropriate releases of information have been signed.
- I understand that all written, video, auditory, and electronic communications and records are protected by this policy. These records are maintained in a locked or password protected environment and stored according to the requirements of the Colorado Mental Health Statute.
- I understand that, unless otherwise agreed upon by both me and my therapist, all services will be conducted at the office address listed on this form. I understand that I may encounter other clients and professionals at the location of services and release my therapist from unintentional liability that this may incur.
- Other information specific to mandatory disclosure of information is further delineated in the *Client Disclosure Statement* form and I have read and understand this information.

FEES AND PAYMENT

- I understand that the fee for individual, couple, and family psychotherapy is $100.00 per 50-minute session or $150.00 per 80-minute session. The fee for group psychotherapy is $40.00 per session. Other options for contracting therapeutic services may be available on an individual basis.
- I understand that all fees are due at the time of service.
- Other information specific to fees and payment is further delineated in the *Fee Agreement Form* and I have read and understand this information.

CANCELLATION POLICY

- I understand that at least 24 hours advanced notice must be provided if I need to cancel or reschedule a session. Because my appointment time has been reserved specifically for me, all changes or cancellations received with less than 24 hours notice will be billed at my regular rate.

MISSED SESSION POLICY

- I understand that my full fee will be charged for any missed appointments or appointments canceled with less than 24 hours notice without just cause (i.e. an emergency, inclement weather, etc).
- I understand that most third party payment sources, such as insurance companies and victim compensation, do not pay for missed sessions and thus I am solely responsible for these fees.

SUPERVISION AND CONSULTATION

- I understand that it is standard practice and of benefit to me as a client for my therapist to receive regular and ongoing clinical supervision or peer consultation by a qualified clinician. I further understand that my therapist is currently receiving regular clinical supervision and/or peer consultation and I understand that for purposes of professional integrity, billing, and continuity of care, this is necessary. I further agree, without further written consent, to allow my therapist to release information on an "as needed basis" about me for these purposes.
  My Therapist's Name: **S. David Clift-Willoughby, MA, DAACS**
  My Therapist's Supervisor: **Dr. Reo Leslie, LPC, LMFT, CACIII**

AVAILABILITY AND ANSWERING SERVICE

- I understand that telephone calls and electronic communications can be received at any time via telephone, telephone voice mail, and/or email. It is important to note that when calls ring into voice mail, the messages are picked up regularly and will be returned as soon as possible (generally within 24 hours or the next business day). If I have a major emergency and cannot reach my therapist immediately, I am aware that I may need to seek help at a mental health center or a local hospital. Within the Denver/Boulder metropolitan area, I can always access assistance by dialing 9-1-1 on my telephone.

REPORTS AND PHONE CALLS

- I understand that there is no charge for brief phone calls, messages left on voice mail, and/or electronic communications. Calls or emails lasting longer than 10 minutes will be charged to me on a pro-rated basis. Reports requested by insurance companies, physicians, etc, will not be released without my permission. Charges for reports will be pro-rated based on the $100.00 per hour rate.

TERMINATION OF THERAPY

- I understand that if I feel I am approaching readiness to leave therapy I will speak with my therapist regarding this. Likewise, if my therapist feels I am approaching readiness to leave therapy, this will certainly be discussed with me as well. Additionally, my progress and status will also be discussed and reviewed with me on an on-going basis.
- I understand that I may seek a second opinion from another therapist or may terminate therapy at any time. If I do decide to terminate therapy, I agree to inform my therapist as far in advance as possible, or if this is not possible, at the beginning of the last session at which I am to meet. In a therapeutic relationship of any length, termination and closure are very important processes and most people find their experience to be incomplete if there has not been an adequate opportunity to discuss the reasons for ending. Advance notice also allows both me and my therapist to pace the therapeutic process appropriately.

I have read the preceding information and I agree to the aforementioned terms:

Client Name: ____

Client Signature: ____________________________________ **Date:** __________________

Therapist/Witness: ___________________________________ **Date:** __________________

(If Applicable)

Additional Client Name	Signature	Date
______________________	______________________	________________
______________________	______________________	________________
______________________	______________________	________________