

INFORMED CONSENT FORM

This document contains important information related to professional counseling services, processes, ethics, and other policies that will guide the therapeutic relationship. The practice of professional counseling is governed by various laws, regulations, and codes of ethics. These regulations and codes require that you are aware of specific parameters, policies, and procedures that inform your receipt of professional services. Therefore, we are providing this information in writing.

- 1. Regulation of Psychotherapists** – The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of counseling. The agency, within the department, that has direct responsibility is the State Grievance Board: 1560 Broadway, Suite #1350, Denver, CO, 80202; (303) 894-7766.
- 2. Client Rights and Important Information** – It is important you know the following information:
 - a. You are entitled to receive information about my methods of therapy, duration of therapy, and fee structure for services provided. This information will be provided to you upon request.
 - b. You are entitled to seek a second opinion from another counselor or to terminate the counseling relationship at any time.
 - c. Sexual intimacy between a counselor and their client is never appropriate. If sexual intimacy were to occur, it should be reported to the State Grievance Board listed above.
- 3. Notice of Confidentiality** - In general, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. Client consent to release information must be done in writing via a *Release of Information Form* (available upon request). There are some exceptions to confidentiality, which include the following:
 - a. I am required by law to report any suspected incident of child abuse or neglect to law enforcement;
 - b. I am required to report threat of imminent physical harm by a client to law enforcement and to the person(s) threatened;
 - c. 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. I am required to report any suspected threat to national security to federal officials.
 - d. In most cases, when treating a minor client (child under the age of 18) confidentiality does not apply to communication with parent(s)/guardian(s) of that child client. The child's counselor can and will consult with the parent(s)/guardian(s) as necessary unless:
 - i. The child is emancipated, or
 - ii. The child is over age 15 and has sought out counseling services on his/her own.
 - e. In most cases, the counselor will conduct periodic joint meetings between children/adolescents and their parent(s)/guardian(s) as part of the therapy process.
 - f. Within the context of couple or family treatment there will be a "no secrets" policy, meaning that all members of the couple or family in treatment together are treated equally and secret are not kept by your therapist within the therapeutic setting.
 - g. In regard to client rights of confidentiality in counseling, the protections of the mental health statutes in Colorado exceed those of the Health Insurance Portability and Accountability Act (HIPAA). I am compliant with the requirements of the mental health statutes and therefore also with HIPAA requirements. I do not transmit client information or records electronically.

4. **Notice of Privacy Rights** - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. One of the requirements of the Privacy Rule is that you receive a Notice of Privacy Practices (<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html>) that describes your rights and protections regarding your health care records and the Uses and Disclosures for Treatment (<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html>) that describes the parameters of healthcare operations, including psychotherapy and counseling procedures. Please refer to this important HIPAA information via the links provided to you prior to initiating your first counseling appointment. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment.

5. **Telephone & Emergency Procedures**

- a. Scheduling Appointments – please call **(720) 460-0388** to schedule, reschedule or cancel counseling appointments. In the event that I do not answer the phone, please leave a detailed message about the nature of your scheduling needs.
- b. Emergency Contact – in the event you are in imminent danger or having a medical emergency please call **911** or go immediately to your local emergency hospital.
- c. Informed Consent for Telephone, Electronic, and Mail Contact - **By signing this contract, you agree to give Dr. Chris Hull, LPC, NCC, ACS permission to contact you via the following:** (Check all that apply)

_____ Home Phone: _____

_____ Mobile Phone: _____

_____ Work Phone: _____

_____ Email Address: _____

6. **Divorce and Custody Litigation** – If you are involved in divorce or custody litigation, my role as professional counselor is not to make recommendation to the court concerning custody or parenting issues. By signing this Informed Consent you agree **not** to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

7. **Session Length, Fee Information, and Duration of Counseling**

- a. Session length - Counseling sessions are scheduled for 50 minutes beginning at the top of the hour, with 10 minutes set aside at the end of the session for record keeping and administrative duties.
- b. Cancellation policy - Barring emergencies, clients must cancel and/or reschedule appointments by notifying me at least 24 hours prior to the scheduled appointment hour. Clients will be billed up to the full amount of the agreed upon payment of services in instances when appointments are missed or canceled within the 24 hour timeframe.
- c. Current fee for service - \$150 per 50 minute session.
- d. Accepted payment – I accept cash, check, and credit card payment. I currently do not accept insurance. Receipts can be provided upon request.
- e. Termination/Duration of counseling – Termination and duration of counseling is best determined in joint agreement between client and counselor; both the client and counselor have the right to recommend termination of counseling or referral of client to higher levels of care when appropriate.

In consideration of the benefits to be derived from professional counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Dr. Chris Hull, LPC, NCC, ACS from any and all claims, demands, actions or causes of action of whatsoever kind and nature related to the counseling process.

I have read and understood the preceding information and understand my rights as a client. I understand that these comments are prerequisite to my receiving and continuing counseling.

Signature of Client/Legal Representative

Print Name

Date

Additional Client Signature (Spouse, /Partner, Family Member)

Print Name

Date