Disclosure Statement

Kimberly Mathewson, Psy.D.
Licensed Psychologist #4220
490 South Logan Street
Denver, CO 80209
303-909-5601

Education/Degrees

Psy.D., University of Denver, Denver, Colorado: Doctor of Psychology, 2013
M.A., University of Denver, Denver, Colorado: Master of Clinical Psychology, 2010
B.A., University of Colorado, Boulder, Colorado: Bachelor of Arts, 2006

Regulation of Psychotherapists

The Colorado State Department of Regulatory Agencies regulates the practice of both licensed and registered persons in the field of psychotherapy. Concerns or complaints regarding the practice of psychotherapy may be directed to the Department of Regulatory Agencies: State Board of Psychologist Examiners, 1560 Broadway, Suite 1350 Denver, CO 80202 (303) 894-7800.

As to the regulatory requirements applicable to mental health professionals: Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Professional Counselors must hold a masters degree in their profession and have two years of post-masters supervision. Licensed Psychologists must hold a doctorate degree in psychology and have one year of post-doctoral supervision. Licensed Social Workers must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

Client Rights and Important Information

- You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration (if known) of your therapy, and my fee structure for services.
- You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate and should be reported to the Department of Regulatory Agencies.

- Generally speaking, 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. There are several exceptions to confidentiality, some of which are listed in section 12-43-218, and the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. Some of these exceptions include: (1) I am required to report any suspected incident of child abuse or neglect, within the stipulations of state law, to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened, including those identifiable by their association with a specific location or entity; (3) 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; (4) I am required to report any suspected incident or exploitation of an at-risk elder abuse or neglect, within the stipulations of state law, to law enforcement and (5) I am required to report any suspected threat to national security to federal officials.

I have read the preceding information and I understand my rights as a client or as the client's responsible party. I also acknowledge I have received a copy of this Disclosure Statement.

_____ _____

Client's or Responsible Party's Signature Date

_____ _____

Therapist/Witness Date

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

_____

Consent for Treatment and Financial Agreement

I voluntarily consent to participate in mental health and/or consultation services with Kimberly Mathewson, Psy.D. and PhoenixRISE. Dr. Mathewson is registered with the state of Colorado as a Licensed Psychologist.

- Rate for Individual, Child/Adolescent, Family, Couple's Treatment, Consultation by Phone or In Office is: $130.00 (45 Minute session)
- Telephone calls under 15 minutes are free of charge. Any call 15 minutes or more will be charged a base rate of $35.00 per 15 minutes and $10.00 for each additional 5-minute period.

***If you are currently receiving a rate reduction, which has been previously arranged with Dr. Mathewson, please enter this session (45 Minute session) rate here: _____.**

- Therapy Partner Corporation is an outsourced billing agency utilized by Dr. Mathewson and PhoenixRISE. Therapy Partner Corporation will manage all administrative and billing functions associated with the practice. This will allow the practice to continue to focus on service-oriented tasks aimed at ensuring quality care. Payment for your treatment will be electronically deducted from a debit/credit card account at the time of service, unless check or cash payment is preferred. Visa, Master Card, and Discover cards will be accepted. Please see Electronic Payment Authorization Form.
- I understand that I am responsible for payment at the time services are rendered. I agree to give ***at least* 24 business hours notice** in the event I need to cancel or change an appointment. **For appointments on Mondays, notice of cancellation will be made by the preceding Friday.** If I fail to give such notice, I understand that I will be charged a full session fee as a late cancellation fee. Further, I understand that if I fail to call and do not show up for an appointment I will also be charged the full fee for that missed session.
- I understand that my insurance company will not be billed for services/therapy, or for cancelled or missed appointments. If I wish to submit a bill to my insurance provider, I understand that I am responsible for such a submission.
- If a report, letter or consultation by an outside party is requested, I understand that I will be billed the usual hourly rate for the time needed to prepare the document, or to conduct an in person consultation. Telephone consultations will be billed at the aforementioned rate in this instance as well.
- Any bill not paid within thirty days will be assessed a service charge at the rate of 1.5% per month. In the event that billing efforts fail, delinquent accounts will be subject to Collections Recovery at the discretion of Kimberly Mathewson, Psy.D. and PhoenixRISE. Additionally, an attempt will be made by Dr. Mathewson to develop a payment plan with clientele who wish to seek this option for outstanding balances. By signing this agreement you are agreeing to this procedure.

I have read and understand the Consent for Treatment and Financial Agreement.

Client Signature:_____ Date:_____

Client Signature:_____ Date:_____
(Parent or Guardian if client is a minor)