8 W Dry Creek Cir, Suite 208
Littleton, Co 80120
720-696-0261

DISCLOSURE STATEMENT AND POLICIES

Hideaway Counseling provides professional counseling from a Christian perspective while respecting and working with the unique values and perspectives of each client. This disclosure statement is between you, the client, and your therapist.

1. Hideaway Counseling is located at 8 W Dry Creek Cir, Suite 208, Littleton Co 80120 and the phone number is 720-696-0261.

2. Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must also sign this disclosure statement on behalf of their minor child over the age of twelve (12) but under the age of fifteen (15) years old, unless said minor is voluntarily seeking psychotherapeutic services for themselves without their parent's or legal guardian's knowledge or consent. In this case, the minor who is between the age of twelve (12) and fourteen (14) years old, in addition to this disclosure statement, shall also sign a Voluntary Consent for Psychotherapeutic Services form.

3. In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is Hideaway Counseling's policy to seek the consent of both parents/legal guardians, however this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination, and this is the governing policy unless the child's health, safety, and welfare could be at risk. If this is the case, you must inform Hideaway Counseling so that appropriate action for the protection and welfare of the child may be taken. This disclosure statement contains the policies and procedures of Hideaway Counseling and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

4. You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing at any time during therapy.

4. Levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

CLIENT RIGHTS AND IMPORTANT INFORMATION

Fees:

1. My fee structure, services, and fee policy provided are outlined as follows:

a. $105.00 per hour for individual, couples, or family counseling. Client consultation services will be provided on a pro-rated fee based on $105.00 per hour. Consultation services may include but are not limited to phone calls; email review and responding; parent or other third-party involvement in treatment updates provided in person, by phone or by email; and/or parenting education or other psychoeducation.

b. It is the policy of my practice to collect all fees at the time of service unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

c. Therapy fees and treatment are based on a **45-50 minute** clinical hour instead of a 60 minute clock hour so that I may review my notes and assessments on your behalf.

d. I am not a Medicaid provider. If you have Medicaid coverage that includes mental health services, I am not able to offer mental health services to you.

e. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $315.00 per hour.

Second Opinion and Termination:

2. You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

Sexual Intimacy:

3. In a professional relationship (such as psychotherapy), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA as listed above.

Confidentiality:

4. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. The psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

a. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. § 12-43-218). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

b. Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party.

c. As a licensure candidate, I am under the supervision of Lisa Vander Griend, LPC, RPT-S, ACS. As such my supervisor will be monitoring the therapy services I provide you. You may be introduced to my supervisor, if we deem it appropriate, and information you share with me may also be shared by me with my supervisor. As part of my supervision, my supervisor may review my case notes, clinical work, and/or request to

observe your therapy sessions. Any requests to observe our therapy sessions, whether live or by video/audio recording, will require a separate consent to observe/record our sessions. My supervisor will adhere to all the same policies and procedures in this Disclosure Statement, including all provisions relating to confidentiality. Any disclosure of confidential and protected health information to providers or parties outside Hideaway Counseling will require you to sign a separate Authorization for Release of Information.

"No Secrets" Policy:

5. When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your therapist is required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. Your therapist will use his or her best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your therapist will first give the individual the opportunity to make the disclosure themselves. This "no secrets" policy is intended to allow your therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

6. "No Secrets" in Custody Circumstances Policy:

When treating a Client who is a Minor under the age of fifteen (15) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email when sending emails pertaining to the Client's treatment (i.e. all communication will "cc" both parties), unless all legal guardians have agreed to designate only one of themselves as a primary contact. This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, I reserve the right, in my sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, I will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or regulations regarding the protection of the health, safety, and welfare of the child/ren.

This policy will also be extended to clients who are over the age of twelve (12) but under the age of fifteen (15) when and if their parents or legal guardians are notified of their receiving psychotherapeutic services.

7. Extraordinary Events:

In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Lisa Vander Griend
ADDRESS: 16965 Pine Lane, Suite 103, Parker, CO 80134
TEL: 720-842-5608
CREDENTIALS: Licensed Professional Counselor

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

8. Maintenance of Client Records:

As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of Licensed Professional Counselor Examiners, I will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later (or, in the case of a client who is 17 years of age or younger, I will maintain the Client Record for 7 years past the date they become 18). I cannot guarantee a copy of your Client Record will exist after this seven-year period.

9. Electronic Record Keeping:

My normal business hours are Monday through Friday 11:00am to 5:00pm. However, as a therapist, the majority of my business hours are devoted to seeing my clients in therapy, which means I am not always available for immediate contact via phone, text, or email. This is especially true for emergencies, as I am not equipped to respond immediately.

The best way to contact me is via email or phone. Every effort will be made to respond to you in a clear and timely manner. Voicemails sent to my phone will typically be returned within 48 hours, excluding Saturdays, Sundays, and holidays. Every effort will be made to return voicemails sent to (720) 696-0261 and emails sent to hideawaycounseling@gmail.com within 48 hours, excluding Saturdays, Sundays, and holidays. It is my policy to return all phone calls, texts, and emails during my normal business hours (referenced above). I also reserve the right, in my sole discretion, to return communication outside of these hours; but any communication which I initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of my normal business hours.

10. Spiritual Counseling:

As a Christian Counselor, faith is an important component within counseling, and I strive to honor your faith and beliefs in the process. In addition to using psychological approaches and methodology, I may from time to time offer to incorporate passages of scripture, prayer, or other spiritual disciplines into my work. You retain the right to decline the integration of spiritualty and psychotherapy, and this does not prohibit our ability to work together in a traditional

psychotherapy capacity.

AS A CLIENT:

As a Client of Hideaway Counseling, by signing this Disclosure Statement and Consent Form, you agree and understand the following:

1. I understand that there may be times when my therapist(s) may need to consult with a colleague or another professional, like an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Additionally, my counselor may discuss my case with members of the Highline Counseling Group treatment team in the interest of providing me with adequate and ethically sound care. I understand that I will need to sign a separate Release of Information for any discussion or disclosure of my confidential and protected health information to another professional outside of Hideaway Counseling, besides an attorney retained by my therapist. Further, I am aware that Hideaway Counseling cannot guarantee my anonymity when I walk through common or administrative areas of the building in which Hideaway Counseling is housed en route to my counseling appointment.

2. I understand that communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. I understand that should I want Teletherapy, I will discuss my request with my therapist. I understand that it is in my therapist's discretion whether to accommodate my request for Teletherapy.

3. I understand that my therapist, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via social media. Any such request will be rejected in order to maintain professional boundaries.

4. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

5. I understand my therapist provides non-emergency therapeutic services by scheduled appointment. If my therapist believes my therapeutic issues are above her level of competence, or outside of her scope of practice, she is legally required to refer, terminate, or consult. If, for any reason, I am unable to contact my therapist(s) by telephone number she provided me, (720) 696-0261, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. Hideaway Counseling does not provide after-hours service without an appointment. If you must seek after hours treatment from any counseling agency or center, you will be responsible for any fees due. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call by the end of the next business day, excluding holidays and weekends.

6. If my therapist believes my therapeutic issues are above her level of competence or outside of her scope of practice, my therapist is legally required to refer, terminate, or consult.

7. I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payor, etc. does not compensate my therapist I

understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payor, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my entire client file. I understand that once my insurance company receives the information I have no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report Hideaway Counseling submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.

8. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked at the time therapy at Hideaway Counseling is terminated.

9. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to sign a separate form in order to participate in therapy.

10. I understand that should I choose to discontinue therapy for more than sixty days by not communicating with my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the sixty-day period by discussing my decision to resume therapy services with Hideaway Counseling. Ability to resume therapy after sixty days will depend upon my therapist's availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least sixty days. I understand that my therapist may send me a written "Notice of Termination of Therapy Services" after sixty days has passed since my last session and our therapeutic relationship shall be terminated.

11. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

12. Because of the nature of therapy, I understand that our relationship must be different from most other relationships. To protect the integrity of the counseling process our relationship must remain solely that of psychotherapist and client. This means that my therapist cannot be my friend. My therapist cannot have any type of business relationship with me other than the counseling relationship (i.e. My therapist cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling). My therapist cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client. My

therapist cannot hold the role of counselor to his relatives, friends, the relatives of friends, people he knows socially, or business contacts.

13. I understand that should I cancel within 24 hours of my appointment or fail to show up to my scheduled appointment, excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.

14. I also affirm, by signing this, I am at least fifteen (15) years old and consent to treatment and therapy services here at Hideaway Counseling. If I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15) and for whom I am requesting therapy services here at Hideaway Counseling. I understand it is Hideaway Counseling's policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren's treatment in accordance with DORA policy.

15. If I am the non-custodial parent signing this consent form for my minor child/ren's treatment in accordance with DORA's policy, I understand that my access to my child/ren's treatment and client record may be limited by court order.

16. In the event that I am over the age of twelve (12) but under the age of fifteen (15) years old, I affirm that I am consenting to treatment and psychotherapeutic services here at Hideaway Counseling, and that I have been advised by Christine McGrath of the importance of involving my parents and/or legal guardians, and that I have willingly signed the Voluntary Consent for Psychotherapeutic Services form.

17. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with Hideaway Counseling, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. I also understand that it is Hideaway Counseling's policy to request and seek consent from both my minor child/ren's parents, but that such consent does not supersede the Court Order Custody Agreement and/or Parenting Plan. By signing this form, I understand and consent to Hideaway Counseling's "No Secrets" in Custody Circumstances Policy as outlined above. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A court can appoint professionals with the expertise to make such recommendations.

* 16. By signing this form, I affirm that I am fully informed of the therapy services I am requesting, and that Hideaway Counseling is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

Client Name/Signature	DATE
Parent/Legal Guardian Signature (Please specify relationship to the client)	DATE
Parent/Legal Guardian Signature (Please specify relationship to the client)	DATE
Therapist Signature	DATE