Disclosure and Consent Form

Broomfield Integrative Counseling
Nicholas R. Simpson, MA, MS, LPC
Licensed Professional Counselor, #11861

80 Garden Center, Suite 250
Broomfield, CO 80020
Phone/Voicemail: (720) 254-3050

Credentials and Training

MA, Counseling, Denver Seminary (2011)
 Internship in Community Counseling, Denver Rescue Mission (2010-2011)
Graduate Certificate, Leadership, Denver Seminary (2011)
MS, Electrical Engineering, University of Missouri Science and Technology (1985)
BS, Electrical Engineering, University of Missouri Science and Technology (1983)

Regulation of Counseling

The Colorado Department of Regulatory Agencies, Mental Health has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselor, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has the responsibility specifically for unlicensed counselors is the State Grievance Board. Any concerns or complaints about licensed or unlicensed mental health professionals may be addressed to the State Grievance Board, 1560 Broadway Ave, Suite #1350, Denver, CO, 80202, (303) 894-7800.

Client Rights and Important Information

The Colorado Department of Regulatory Agencies requires that you be provided the following information when seeking counseling services.

1. You are entitled to receive information from your counselor about methods of therapy and the therapeutic techniques used. Please ask for this information if you wish to receive it.
2. You are entitled to an estimate of the duration of your therapy, as possible.
3. You are entitled to information about my fees and requirements for payment.
4. You may seek a second opinion from another mental health professional or terminate therapy at any time.
5. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, the Division of Registration, Mental Health Section (State Grievance Board).

Confidentiality

The confidentiality of the counseling provided to you is protected by law. Generally, as a therapist I cannot disclose this information provided by or to the client without written consent.

There are several exceptions to confidentiality as follows per C.R.S. 12-43-218.

1. I am required to report any suspected incident of child abuse or neglect 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.
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 threat to national security to federal officials.
5. I may be required to disclose treatment information when ordered by a court.

Fees, Payment and Scheduling

It is my policy that each person receiving counseling or testing services pay for such professional services at the time rendered. Any other arrangements must be made in advance. A $30 administrative fee will be charged on all checks that are returned for non-sufficient funds.

My fees are based on forty-five/fifty (45/50) minute sessions. My normal per session fee is $125/hr(individual) & $150/hr (couples/family). Phone consultations are the patient’s responsibility and are billed in 15-minute increments. All calls over five minutes will be billed accordingly. Any sliding fee rates or discounted rates require

clients to provide financial information in the appropriate Sliding Fee Scale form and sign a Sliding Fee Agreement specifying a discounted fee rate.

Any additional expenses related to legal actions that require me to consult with attorneys are the responsibility of the client and will be billed as such. These may include but are not limited to phone calls, written reports, court appearances and collection fees when the client is delinquent on their payments.

At times it may be necessary for the client to miss or cancel appointments. The client is required to communicate any scheduling changes or missed appointments as follows:

- Changes or cancellations must be made at least 36 hours in advance of any workday, Monday thru Friday.
- When a Monday appointment must be cancelled, the cancellation must be made by the preceding Friday.
- Changes or cancellations received less than 36 hours in advance may be charged a regular per-session rate.
- Any missed appointment with no call received will be charged the regular per-session rate.

Insurance

While many insurance policies provide partial coverage for mental health services, I do not accept insurance nor do I take responsibility for billing insurance companies for my professional services. This allows me to provide reasonable costs and maintain the quality of counseling service that makes it available to those who cannot otherwise afford it.

Your insurance contract is between you and your insurance company; it is not an agreement between the insurer and my business. Therefore, your account with me is your responsibility regardless of insurance coverage that may be available to you through your insurer. All clients must pay in full all amounts due for services including, but not limited to, testing, educational resources, and telephone consultations.

* Note: Most insurers do not cover missed appointment charges.

Supervision

My commitment to the highest quality of care to clients requires that I participate in professional supervision, peer consultations and group consultations. The confidentiality of clients is protected in all these clinical forums. Also, I may be required to make video or audio recordings of sessions for supervision and/or consultations, in which event you will be informed and be required to sign a consent form to approve such recording.

Client Agreement and Consent to Treatment

I authorize treatment of the person named below and agree to pay all fees for such treatment. I agree to pay all charges for myself and members of my family shown by statements promptly, upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days. Accounts with no activity for 30 days may be sent to a collection agency along with necessary client information.

I attest that I have read the information above, that I am aware of the therapist's education and credentials, that I understand the conditions stated above, and I agree to receive counseling under these conditions.

______________________________	______________________________
Patient's Name	Spouse's/Partner's Name
______________________________	______________________________
Signature of Patient or Legal Guardian	Signature of Spouse/Partner (required in joint therapy)
________________	________________
Date	Date
______________________________	________________
Signature of Witness	Date