DISCLOSURE STATEMENT AND FEE AGREEMENT

1. INFORMATION:

Kara Bates, MA, LMFT
1333 W. 120th Ave. Ste. 218
Westminster, CO 80234

2. CREDENTIALS:

Licensure: Licensed Marriage and Family Therapist, License #640
Degrees: M.A. in Clinical Psychology, Emphasis in Marriage and Family Therapy

3. REGULATION OF PSYCHOTHERAPISTS

The Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. Questions and complaints may be addressed to the Grievance Board, which is located at: State Grievance Board, 1560 Broadway, Room 1340, Denver, CO 80202, (303)894-7766.

4. SERVICES ARE PROVIDED IN ACCORDANCE WITH THE FOLLOWING GUIDELINES:

- I am entitled to receive information about methods of therapy, the techniques used, and the duration of my therapy.
- I can seek a second opinion from another therapist or terminate therapy at any time.
- Sexual intimacy between a therapist and client is never appropriate and is illegal in the state of Colorado. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies.
- 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 which include: (1) suspected incident of child abuse or neglect to law enforcement; (2) threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) initiation of 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) suspected threat to national security to federal officials; (5) significant clinical information under court order, and; (6) responding to legal action against therapist by client.
- If I participate in group therapy, it is necessary for me to agree to protect and respect the privacy of other group members. I agree not to share personal information, including the names of other group members, with people outside of the group. I may expect other group members to show the same respect for my confidentiality.

5. CONSENT TO TREATMENT

I request services from Kara Bates, MA, LMFT.

6. ELECTRONIC RECORDS

I understand that my Protected Health Information (PHI) will be stored electronically on HIPPA compliant servers operated by Therapy Appointment. Claims for insurance payments will also be submitted electronically through Office Ally.

7. DESTRUCTION OF RECORDS:

I understand that the clinical records from this treatment episode may be destroyed if no further treatment is rendered within seven years of the date of termination of this episode (or ten years from the date client reaches age eighteen, if client is a minor).

8. AS A CLIENT, I HAVE THE FOLLOWING RIGHTS:

- To revoke this consent at any time.
- To receive treatment only if I or my legal guardian gives permission in writing.
- To be treated with respect and recognition of my need for dignity.
- To receive services based on my individual needs, in a setting, which supports my individual freedoms.
- To actively participate with my provider in creating a plan for my care. To include other people I think would be helpful in creating my care plan.

- To confidentiality, and to expect that none of the information about my treatment will be given to anyone without your permission except as required by law.
- To refuse treatment unless I am court ordered to receive services and to be informed of the consequence of my refusal.
- To have my family members involved in my care, at my request. To be represented by my guardian, in the case that I am unable to participate in my treatment decisions.
- To receive written notification and request a second opinion if I disagree with my provider's decision to reduce or discontinue my services, or deny me inpatient services.
- To not be discriminated against due to race or ethnicity, sex, age, disability, sexual orientation, genetic information or source of payment.
- To be informed of the rights in a way I understand.
- To complain about services at any time without retaliation.
- To be informed of the complaint/grievance procedure.

I have read and agree to the preceding information and understand my rights as a client/patient. I also acknowledge that I have received a copy of this Disclosure Statement and a copy of the Notice of Privacy Practices.

Client Name (please print)	Date
Client Signature (Parent or legal guardian)	Date
Client Signature (Parent or legal guardian)	Date
Kara Bates, MA, LMFT	Date