ABIDING HOPE COUNSELING

PROFESSIONAL DISCLOSURE STATEMENT, INFORMED CONSENT, HIPPA CLIENT RIGHTS & THERAPIST DUTIES, & ABIDING HOPE POLICIES

Elizabeth Moffitt, M.A., LPCC, NCC

Call or Text 719-285-7466 emoffitt.ah@pm.me

Welcome, and thank you for allowing me to take part in your life's journey. This statement will inform you of my background, counseling approaches, and your rights. This document is mandated by the State of Colorado and the American Counseling Association. If you have any questions, please feel free to discuss them with me at any time. This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

The Therapeutic Process You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in challenges or even considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can support you and do our very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

EDUCATION & CREDITIALS

Elizabeth Moffitt, M.A., LPCC, NCC Licensed Professional Counselor Candidate # LPCC.0017108 Services: Providing individual, child (8 years +), adolescent, women, marriage, and family counseling. Degrees**:** Master of Arts: Liberty University, Professional Counseling (09/2019); Bachelor of Arts: Covenant College, Sociology, 2002. I also am a National Board Certified Counselor (NCC). I am under the supervision of Linda Seibert, MA, NCC, (LPC license #0014503)

STATEMENT OF FAITH & THEORECTICAL APPROACHES I, in accordance with a Christian framework, take components from Cognitive-behavioral psychology, Solution-focused, Rational Emotive Behavioral Therapy (REBT), and Person-centered therapies and provide education to conduct all services. I generally approach therapy from an integrative theoretical orientation, which means that I endeavor to choose theoretical approaches suited to the particular presenting issues and concerns of the client (eclectic). I will incorporate the Christian faith *as requested* by the client as indicated in the intake questionnaire.

My counseling services address concerns or issues including, but not limited to:

- Alcohol/drug/substance use and addiction (both with individuals and their family members)
- Depression and anxiety
- Shame, self-esteem, and self-image
- Wellness, spirituality, and mindfulness
- Grief, loss, and trauma
- Couples and family concerns such as: conflict resolution, boundary setting, intimacy, attachment, and communication difficulties
- Developmental and life transitions
- Past traumas including Post-Traumatic Stress Disorder (PTSD)
- Somatic Health Issues
- Professionals and moms in every season dealing with self-care and burn out

DISTINCT REQUIREMENTS APPLICABLE TO SPECIFIC MENTAL HEALTH PROFESSIONALS: The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7800. The regulatory requirements for mental health professional provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a master's degree in their professional and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of

post-doctoral supervision. A Licensed Social Worker must hold a master's 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 behavior 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 listed in the State's Database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Colorado Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Colorado Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.
4. I am required by HB 14-1271 to report any threats against locations such as churches, schools, theaters, workplaces, etc. to law enforcement.
5. When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information related to my concerns. By signing this Disclosure Statement and agreeing to treat with us, you consent to this practice, if it should become necessary.
6. At all times, I reserve the right to consult with other therapists as needed, and to brief therapists covering for me while I am out of town or during a personal emergency. I also am a counseling intern student under supervision. In general, the information divulged would not identify you personally, except in co-therapy agreements. In a case of a personal emergency, it might be necessary to divulge your name and phone number if it became necessary to contact you on my behalf. Such information will be given only in extreme or dire circumstances.
7. Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado Law and HIPAA Standards.
8. If we see each other accidentally outside of the therapy office, your therapist will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge your therapist first, he/she will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Client's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.
- You are entitled to ***receive information from me about my therapeutic methods or techniques***, the duration of your therapy (if it can be determined), and my fee(s). Please ask if you'd like to receive this information.
- At any time, you may ***seek a second opinion from another therapist or terminate therapy***.

- In a professional relationship (such as ours) ***sexual intimacy between a therapist and client is never appropriate***. If sexual intimacy occurs, it must be reported to the Board that licenses, certifies or registers the therapist.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you 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. If you were to default on this agreement, my fee for being required to testify in court is $375/hour with a $1500 minimum retainer fee.

Additionally, if you are a parent or guardian who is consenting to treatment for a minor, by signing this Agreement, you affirm that you are the parent or legal guardian of the child; that you have the legal right to consent to psychological treatment for the child; that there has not been a Divorce Decree or any other Court Order that limits your ability to consent to the child's treatment. If the child's parents are divorced or never married, it is my practice to require BOTH parents to consent to treatment, in compliance with any Divorce Decree or Court Order that may be in place. I will also require a copy of the Divorce Decree or Court Order prior to providing any services to the child, and by your signature below, you

agree to provide it immediately upon request.

If the parents of the child client have remarried or have significant others who may be involved in the child's therapy, I like to meet with all the adults before seeing the child to obtain signed Authorizations for the limited sharing of information regarding the child, and to establish the boundaries for my treatment of the child. My first rule is that none of the adults should ask to speak with me before the child's appointment in front of the child. If you have information to share, please do it privately. Also, I do not generally allow step-parents to make therapy appointments for child clients unless the child's parents have signed an Authorization allowing the step-parent to schedule the child's appointments.

LITIGATION POLICY AND FEES FOR COURT-RELATED SERVICES

I do not want to be involved in your litigation. I do not want to deal with subpoenas or lawyers or having to disclose your confidential information in court. I do not enjoy going to court and I do not want to deal with the negative feelings that can result from court or deposition testimony. The nature of the therapeutic process often involves making a full disclosure with regard to many matters which may be extremely private, upsetting or embarrassing. If you become involved in any legal proceeding during your therapy with me, including but not limited to divorce and custody disputes, or personal injury lawsuits, you agree that neither you, nor your attorneys, nor anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court, in a deposition or in any legal proceeding. By your signature below, you acknowledge my position and agree to abide by my litigation policy.

If you involve me in your litigation, or if you or your attorneys subpoena me to provide my records, testify in court or give a deposition in violation of this agreement and against my stated wishes, I will comply with lawfully issued subpoenas. **My hourly charge for all time related to court cases or litigation is $375 per hour. You also agree by your signature** below to execute and sign a Credit Card Authorization and provide a valid credit card to ensure payment for the time I must spend dealing with your litigation.

If I am subpoenaed to provide records or testimony in violation of this agreement and against my stated wishes, you also acknowledge and agree that you will pay for all of my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition **regardless of which party issues the subpoena or requires me to testify**.

If I am required to testify in court or give a deposition in El Paso County, I will charge an hourly fee of $375 per hour for a minimum of 4 hours, for a minimum of $1500 and this includes preparation time, travel time, and attendance at any legal proceeding. If I am required to testify in court or give a deposition outside of El Paso County, the hourly fee will be $375 for a minimum of 6 hours for a minimum of $2250. If the testimony or deposition exceeds 4 hours (in El Paso County) or 6 hours (outside El Paso County), there will be an additional charge of $375 per hour for every hour spent in court or deposition. When I go to court or give a deposition, I have to clear my schedule and not see other clients, so there is a 48-hour cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for Monday, this office must be notified of any cancellation no later than Noon on the Thursday before. Any cancellations that occur within the 48-hour time frame of the court appearance or deposition are **NON-REFUNDABLE**. I will accept cash, money order, cashier's check, or credit cards for payment of time related to court appearances or deposition. NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES. All payments are due one week prior to the scheduled court appearance or deposition. By your signature below, you expressly authorize me to run these charges to the credit card on file in our office unless you notify me that you intend to make payment by cash, money order or cashier's check.

Finally, if I am subpoenaed by one party to provide records or testimony in violation of this agreement and against my stated wishes, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers. I will NOT perform social studies or custody evaluations. I will NOT provide recommendations regarding possession, custody, access to or visitation with minor children. I will NOT provide medication or medical advice. I will NOT provide legal advice. These services are NOT within the scope of my practice.

Exceptions to Confidentiality (Release of Information): For all clients who are receiving treatment from me (Elizabeth Moffitt, M.A., LPCC, NCC), it is understood that by signing this disclosure statement the client agrees to a *release of information* to staff members, so that I may better serve the individual/couple/family as a therapeutic team. In marriage and family counseling, the therapist holds a "no secrets" policy. All members of the couple or family system attending the sessions are treated equally and "secrets" are not kept by the therapist that require differential or discriminatory treatment of family members. Therefore, confidentiality is limited and not guaranteed in these contexts.

Outside Contact: If we see each other accidentally outside of the therapy office, your therapist will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge your therapist first, he/she will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Services, Billing & Cancellations: Therapy sessions are 50-60 minutes' duration for one session and billed at $90/session unless we have agreed upon another arrangement that will be noted in this disclosure. When an appointment hour is scheduled, **you will be expected to pay for the session unless you provide 24 hours' advance notice of cancellation, except in the case of an emergency**: unexpected illness or hospitalization of yourself or immediate family member, car accident or other car emergencies such as flat tires, dead batteries, or the death of a family member. If you determine more than 24 hours in advance that you may be unable to attend, please contact me via my voice mail number **719-285-7466,** so that you can schedule an alternative time. If you cancel without 24 hours notice, there is a **$90** late cancellation fee (full session fee). If I am running late, you will get your full therapy session. *If you are more than 20 minutes late, you will be considered a late cancellation, charged the full session fee and be rescheduled.* If cancellations occur three times in a concurrent row, then sessions and the client/counselor relationship will be considered terminated and/or a referral to another outside counselor will be given to the client. **I agree to self-pay or paying out-of-pocket, regardless of whether or not I receive any reimbursement from my insurance company. I agree to not dispute this fee if I**

fail to cancel my appointment before 24 hours notice or do not show and will be responsible for the full fee of $90 for the session I missed.

Services are paid for using IvyPay, a HIPPA compliant pay app or Stripe (also HIPPA compliant). You will receive a text requesting your session credit card payment during the initial session. Your credit card will be kept on file in this platform. In some situations, IvyPay does not work with some phone carriers. If this is the case, we will use Stripe and keep your credit card on file. You are also authorizing me to keep your card on file to charge after a session or a missed no-show, less than 24 hours notice appointment using Stripe if IvyPay does not work. Your sessions or cancellations without 24 hours' notice will be charged immediately after the session time. By signing below, you agree for the session and for the cancellation fee of $90 to then be charged via IvyPay or Stripe. I also understand that if my credit card does not accept the charge, I will immediately make the payment to Elizabeth Moffitt, M.A., LPCC, NCC. of Abiding Hope Counseling, LLC. I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owing will be due and paid in full. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due I acknowledge that credit card transactions could be linked to Protected Health Information.

Insurance: I do not directly accept nor bill to any insurance company. Rather, I can provide my clients upon written request with coded insurance receipts (superbill) that clients may submit to their respective insurance company for potential reimbursement. Each client may receive one reimbursement receipt super-bill per quarter free of charge. Additional receipts will be pro-rated at the regular hourly rate. I will not charge nor submit claims for Medicaid clients. Clients must inform us in writing if they have Medicaid, and by agreeing to pay for services they certify that they do not have Medicaid. We cannot accept Medicaid or Medicaid clients at this time.

Session Notes/Records: Client records available upon written request. Treatment summary available for a pro-rated fee. Requests for family members' records must be in accordance with HIPPA and the Privacy Act. As required by HB17-1011 I am informing you that your client records will be destroyed 7 years after the termination of psychotherapy as pursuant to DORA Rules and the Colorado Mental Health Practice Act. Any client not seen or heard from within a 3-month period will be terminated from the caseload. You agree to never audio or video record any session without written approval from me.

Groups & Group Counseling: All group members agree to confidentiality within and amongst the group. Meaning that you will keep private, sensitive, and/or confidential information within the group only and not share it with anyone outside the group, unless you have received written approval to do so. I, Elizabeth Moffitt, MA, LPCC, NCC cannot personally guarantee confidentiality will be kept by other group members if you are participating and you agree and acknowledge this risk.

Current Rates: All counseling sessions are $90 (50-60 min) session or extended session $130 (75 min) (unless otherwise specified). Extra work outside of session is pro-rated at the regular hourly rate per each 10 minutes. Group counseling is $40 a group meeting.

Referrals: If at any point, I determine that your circumstances are beyond my ability, training, or scope of practice or I come to believe that the therapy is not effective, I may refer you to another therapist(s). If you choose to leave the therapeutic relationship expressly or by default, I am not obligated to make such a referral.

Assessments: You may be asked to take one or several different kinds of inventories/tests during the course of treatment. These are used under the strictest confidentiality guidelines. These instruments are used as diagnostic tools that can aid the overall treatment of your situation. I will only use assessments that I have been trained to use.

Minors: If you are a minor, your parents may be legally entitled to some information about your therapy. We will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential. In the State of Colorado, you are entitled confidentiality at age 15 but agree that if another party such as your parents are paying for your treatment that your confidentiality is limited in this regard. Therefore, at a minimum you agree to a release of information (ROI) for billing purposes. You may agree to an additional release of information according to your discretion, but a minimum ROI for billing purposes is required to treat you if you're a minor and someone else if paying for your therapy.

Elected Payer for services other than yourself Anyone you have paying for your services besides yourself, including but not limited to employers or guardians, will be notified of certain PHI including but not limited to appointment dates or times simply due to their having access to billing records. Therefore, to attain our therapeutic services in these instances, you are to an automatic release of information for billing purposes only to the payer of your services.

Phone Contact/Emergencies: I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside my scope of practice, I am legally required to refer, terminate, or consult. If, for any reason, you are unable to contact me by telephone and are having a true emergency, you may call the 24-hour Pikes Peak Mental Health crisis line at (719) 635-7000 or the crisis hotline in your area. Also you may call 911 or check yourself into the nearest hospital emergency room. Be aware that you may leave a voice mail message in a private and confidential mailbox at the above stated number for non-emergencies

as well.

Limits of Services and Assumption of Risks: Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions. Even if one of these forms of therapy is recommended, you understand that like with any therapy you may deny it at any point in time and another methodology or referral will be given to you.

Contact: Any means of contact you provide to me is considered legitimate to use by me in contacting you for any reasons I deem appropriate. You may inform us which method of contact you prefer to be primary. You agree that as a client your email will be added to our e-newsletter and/or client contact list. You may unsubscribe from these lists at your discretion. Subscribing or unsubscribing has no effect on the services we will provide you.

Social Media and Telecommunication Due to the importance of your confidentiality and the importance of minimizing dual relationships, your clinician does not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Our clinicians believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of your therapeutic relationship with your clinician. However, you may feel free to follow Abiding Hope on social media if you choose to do so. If you have questions about this, please bring them up with us or with your clinician when you meet.

Electronic Communication We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. While we may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist. I also use VSEE, a HIPPA-compliant video therapy session platform that can be used and only used by Colorado citizens where I am authorized to practice.

Termination Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. We may terminate treatment after appropriate discussion with you and a termination process if we determine that the psychotherapy is not being effectively used or if you are in default on payment. We will not terminate the therapeutic relationship without first attempting to discuss and/or explore the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified therapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for 4 consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued. In such circumstances, your status as a client may be changed to inactive and you may be terminated from your clinician's caseload. You may change your status to active and be re-instated by simply scheduling an appointment.

PLAN FOR PRACTICE IN CASE OF DEATH OR DISABILITY

In the event of my death, incapacity or disability, I have made arrangements for another psychotherapist to take over my practice, meet with clients, make appropriate referrals to other providers, if necessary, and take all reasonable steps to manage the practice for the benefit of my clients. By your signature below, you authorize my designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes.

Testimonials: As a counselor, we do not solicit testimonials from current or past clients. If you would like to provide a testimonial, you may do so in and of your own accord. By giving a testimonial you grant your permission for me to post it on our website or other promotional materials. Your confidentiality will be kept secure and any names or identifying information given will be changed to ensure your anonymity.

Referrals, Complaints, and Informed Consent If for any reason you feel that I am not meeting your therapeutic needs, I encourage your feedback and will attempt to adjust my approach. If I am not able to resolve your concerns, I am happy to provide you with referrals to other community referrals. I abide by the ACA and NBCC Code of Ethics. If you feel that I am in violation of any of these codes, please inform me and my supervisor or file a complaint with DORA.

Clinical Supervisor: Linda Seibert, LPC, NCC, Licensed Professional Counselor Degrees: Wayland Baptist University, 2015, M.A. Counseling; University of Texas, 1993, B.A. Spanish and Elementary Education. Email: lindajseibert@icloud.com Phone: 719-362-0132

COMPLAINTS If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Colorado Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Circle the service you desire and initial below it:

	Couples Counseling	Co-Therapy	Individual	Family	Group
Initials:	_____	_____	_____	_____	_____

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Elizabeth Moffitt, M.A., LPCC, NCC Date

If client is under 15 years old, Parent(s) or Legal Guardian(s) Name(s) Printed

_____ **DATE:** _____

_____ **DATE:** _____

Client(s) Information: Address: _____

Phone: ______________________________ Email: ____