DISCLOSURE STATEMENT & POLICIES

1.**INFORMATION**

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2.**CREDENTIALS**

Licensure:

Licensed Professional Counselor

Degrees:

- Bachelor of Science in Psychology
- Master of Arts in Counseling
- Doctorate in Behavioral Health

Professional Associations:

- American Association of Sexuality Educators, Counselors and Therapists
- American Counseling Association
- Colorado Counseling Association
- Colorado Counseling Association of Gifted and Talented
- Chi Sigma Iota
- Regis Alumni Counseling Association

Certifications:

- Nationally Certified Counselor
- Post-Graduate Certification in Marriage and Family Therapy
- Post-Graduate Certification in Clinical Sex Therapy
- Diplomate of the American Board of Sexology

Additional Training:

- Addressing the Psychological Health of Warriors and Their Families: PTSD, Depression, and TBI (Certificate of Training From The Uniformed Services University of the Health Sciences)
- EMDR and EMDR Related Techniques for Effective Trauma Treatment
- Imago Relationship Therapy (Certificate of Training)
- Attachment Parenting (Certificate of Training)
- Smart Couples (Certificate of Training)
- Gottman Couples Therapy (Level 1 Certification)
- The Mindful Therapist: Interpersonal Neurobiology (Certificate of Training)
- Professional Leadership in Mental Health (Certificate of Training)
- Psychopharmacology: What You Need to Know Today About Psychiatric Mediations (Certificate of Successful Completion)
- The Science of Happiness (Verified Certificate of Achievement)
- Hypnosis Intensive (Certificate of Training)
- Assessing the Patient in Context: Investigation Neurocognitive and Personality Profiles Associated with Substance Abuse
- Eating Disorders: Separating the Person from the Disease (Certificate of Attendance)
- Healing Trauma through the Body (Certificate of Attendance)
- YOU@CSU: Wellness & Suicide Prevention Case Study via Digital Technology (Certificate of Attendance)
- The Alchemy of Grief (Certificate of Attendance)
- Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals

(Certificate of Completion)

3. **REGULATION OF PSYCHOTHERAPISTS**

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, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical social worker, a Licensed Marriage and Family therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctorial supervision. A Licensed Social Worker 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.

4. **CLIENT RIGHTS AND IMPORTANT INFORMATION**

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy. Please ask if you would like to receive this information. My fee is $120.00 per 45-50- minute session . Telephone calls, written consultations, emails, and telephone consultations may be charged a prorated amount based upon the rate above, with a prorated minimum rate of 15 minutes. 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. 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.

b. Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Therapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy, and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, and so on, or can lead to experiencing anxiety, depression, insomnia, or other reactions. Your therapist may

challenge some of your assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Change will sometimes be easy and swift, but it can be slow and even frustrating.

c. In family therapy, sometimes a decision that is positive for one family member is viewed quite negatively by another family member. In family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of the treatment. "No Secrets Policy" 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.

Appointments (Scheduling, Re-scheduling, and Cancellations)

Your appointment times will be scheduled regularly, and you will be responsible for keeping your appointments. Since scheduling of an appointment Involves the reservation of time specifically for you, a minimum of 24 hours notice (1 full day) is required for re-scheduling or canceling an appointment, unless extenuating circumstances apply. If you cancel with less than 24 hours notice or "no show" your appointment you will be responsible for the full session fee.

Unless special circumstances arise and because my time is limited, having an unexcused absence may result in termination of counseling.

d. You can seek a second opinion from another therapist or terminate therapy at any time.

e. 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.

f. 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 which include: (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;

and (5) I may be required by Court Order to disclose treatment information. Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for his or her minor child/ren, must sign this disclosure statement on behalf of his or her minor child under the age of fifteen (15) years old. This disclosure statement contains the policies and procedures of Angela Nock PLLC 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).

g. 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.

h. **Emergencies:** If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the intake information sheet. I understand my therapist provides non-emergency therapeutic services by scheduled appointment only . If 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**. I do not provide after-hours service without an appointment. If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely 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. When my therapist is concerned about a client's safety, it is her policy to request a Welfare Check through local law enforcement. In doing so, she may disclose to law enforcement officers information regarding my concerns. By signing this Disclosure Statement and agreeing to treatment with me, I consent to this practice, if it should become necessary.

i. **E - Mails, Cell phones, Computers and Faxes:** It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, my e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address. My computers are equipped with a firewall, a virus protection and a password. Please notify me if you decide to avoid or limit in any way the use of any or all communication devises, such as e-mail, cell-phone or Faxes. If you communicate confidential or highly private information via e-mail, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via e-mail. Please do not use e-mail , text messages or faxes for emergencies. Phone calls should be used exclusively for scheduling purposes, otherwise an in office session or phone consultation needs to be scheduled in advance. I checks messages regularly, and strives to return your call within 24 hours or by the end of the following business day. I am not available to return calls, emails, or texts after hours, on weekends, or holidays or when notified that I am out of the office.

5. 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.

6. LITIGATION LIMITATION

Due to the nature of the therapeutic process, and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, and so on), neither you (client), nor your attorneys, nor anyone else acting on your behalf, will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested, unless special circumstances such as Duty To Warn arise. If I am in fact called upon to testify, it is known I am not a forensic therapist, nor am I trained in these matters. It is also agreed upon my maximum hourly rate of $250.00 will be charged for all hours I am out of my office for these proceedings, including any time I am required preparing to testify.

7. PSYCHOLOGICAL PAPERWORK

If you require any psychological paperwork (i.e. FMLA, letters to employers, probation officers, doctors, etc.) I require a minimum of 4 sessions prior to any such documentation. You will also be billed $120.00 per hour (minimum 1 hour) to produce such items.

By signing this form I affirm that I am at least fifteen (15) years old and consent to treatment and therapy services or that 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), for whom I am requesting therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary 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.

_____ _____

Patient Signature/Legal Representative Date

_____ _____

Patient Signature/Legal Representative Date

_____ _____

Therapist Date