Laura McCarthy, PhD, LMFT
7220 West Jefferson Avenue, Suite #407
Lakewood, CO 80235
720-384-4696

DISCLOSURE, TREATMENT, AND FEE AGREEMENT

Degrees and Credentials:
Ph.D. in Marriage and Family Counseling (2006)
M.Ed. and Ed.S. in Marriage and Family Counseling (2002)
Licensed Marriage and Family Therapist #854

Client Rights and Important Information:
Method of Treatment: You may receive information about the methods of treatment, techniques used, duration of therapy if known, and the fee structure. At any time, you may seek a second opinion or terminate treatment. Please be advised that in a professional relationship, sexual intimacy is never appropriate and should be reported to the Department of Regulatory Agencies.

Sessions and Fees: Sessions are typically 60 minutes in length and are billed at $155 per session; upon request, 45-minute sessions (billed at $120 per session) or 90-minute sessions (billed at $225 per session) may be available. Payment for each session is due at the time of each therapy session. If you carry behavioral health insurance, arrangements can be made for payment of services from the insurance company and you will be held responsible for deductibles, co-payments, non-covered services, and/or unpaid balances. You will be billed $50 for missed sessions unless you cancel at least 24 hours prior to your scheduled session. There is a $30 processing fee for checks returned for non-sufficient funds.

Confidentiality: In general, 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. Exceptions to confidentiality include the following: (1) I am required to report any suspected incident of child abuse or neglect; (2) I am required to report suspected incidents of at-risk adult or elder abuse, exploitation, mistreatment, and/or self-neglect; (3) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (4) 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; (5) I am required to report any suspected threat to national security to federal officials; and (6) I may be required by Court Order to disclose treatment information.

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 about my concerns. By signing this statement and agreeing to treatment with me, you consent to this practice if it becomes necessary.

Under Colorado law, 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, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA standards.

I agree not to record our sessions without your consent, and you agree not to record a session or a conversation with me without my consent.

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.

Emergencies: In a mental health emergency, dial 911 or go to your nearest urgent care or emergency center. Non-emergency calls will be returned by the therapist within 1-2 business days.

Concluding Treatment: You may choose to conclude treatment at any time and for any reason. Some clients choose to end therapy when their initial concern has been resolved, and other clients choose to continue in therapy to address other needs and goals. I believe a closing session is an important part of therapy, and will provide a closing session at no charge if requested. If I do not have contact or communication from you for a period of 60 days, I will assume that you consider this episode of care complete and your case will be closed. You can return to therapy in the future if you decide to continue treatment.

Medical Records: A legal written or electronic medical record of your treatment is kept on file during your treatment according to The Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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.

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-Doctoral 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 1,000 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 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.

I understand and agree to the conditions stated above, including policies regarding fees, insurance, cancellations, confidentiality, crisis coverage, and client rights. I also hereby acknowledge that I have received a copy and/or accessed the electronic copy of the provider's HIPAA Notice of Privacy Practices.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Laura McCarthy, PhD, LMFT Date

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CONTACTS OUTSIDE OF REGULAR THERAPY SESSIONS

Non-Emergency Procedures: I provide non-emergency psychotherapeutic services by scheduled appointment, and am not able to provide 24-hour care availability. I access my voicemail and email Monday through Friday, 9:00 am to 5:00 pm, and will return calls or reply to messages within 1-2 business days. I cannot guarantee that I will receive messages left after hours or on weekends until the next business day. You may call or email me regarding scheduling issues or resources to be used outside of sessions. Generally, information relevant to therapy should be reserved for your next therapy session so we have the time to adequately discuss the matter; please let me know if you need to meet sooner than your next scheduled appointment. Communication methods such as email or text inherently may not be 100% secure and confidential--If you choose to communicate with me via these methods, you are consenting to using these mediums despite complete security not being guaranteed.

- You are welcome to leave me a message with updates on your concerns between sessions if a response is not required.
- You are also welcome to leave me a message and to request a response--Calls (or emails, with your consent) are billed in 15-minute increments ($35 per 15-minute increment). I generally can waive this charge for infrequent contacts requiring less than 15 minutes unless repeated contacts are needed.

Scheduling, Cancelling, Rescheduling: You may contact me to schedule a session, or to cancel or reschedule a session via phone or text (720-384-4696), or via email (Laura@McCarthyTherapy.com). I can also send you text-message reminders about upcoming sessions, to which you can reply to confirm or cancel. (The reminder text-message will come from my reminder service, with the number displaying as 520-413-7474.) If you would like to contact me to discuss any other matters, or to schedule a new time to meet, please contact me at my main number: **720-384-4696**. I cannot directly reply to messages sent through the text-message reminder service.

Emergency Procedures - Crisis Services – *If you (or a family member) are experiencing an emergency that needs immediate attention, proceed to your nearest hospital emergency room or dial 911. Other highly urgent concerns should be addressed by calling Rocky Mountain Crisis Partners at 1-844-493-8255; this is a 24-hour crisis line providing support, stabilization, and referrals for assistance, and serves all Denver-Metro counties. You can also text "TALK" to this organization at 38255 to receive help and support via text, or you can go to their website (coloradocrisisservices.org) for further information including a list of centers for walk-in crisis support, and online chat with a trained counselor.

Written Reports: I can provide a written report or letter at your request (e.g., a treatment summary). I bill in 15-minute increments ($35 per 15-minute increment) for the preparation of reports or letters, and can provide you with an estimate of preparation time expected if desired.

Legal Consultations/Proceedings: If you request that I consult with your attorney or if I am required to appear in a legal proceeding for a current or former client, my usual rate of $155 per hour will be charged for all time associated with this request. Be advised that significant time (often several hours) is usually needed to cover a broad spectrum of associated activities such as case review, consultation regarding relevant legal issues, report writing, travel time, testimony, courtroom waiting time, etc. Please consult with me prior to initiating a formal request so we may discuss an estimate of how much time will be required, what fees are

likely to incur, and possible benefits and risks of requesting my testimony or a report. Please refer to the "DISCLOSURE, TREATMENT, AND FEE AGREEMENT" for particular limitations and concerns regarding testimony in divorce/custody cases, especially regarding my inability to make any recommendations regarding custody.

Social Media Policy: I do not initiate or respond to friend requests or other online invitations on social media platforms (such as Facebook, LinkedIn, Instagram, etc.). This is due to needing to protect your confidentiality as a client and to avoid blurring boundaries in our therapeutic relationship.

I understand and agree to the conditions stated above, including policies regarding emergency and non-emergency contacts, fees for services outside of regular sessions, and policies pertaining to legal consultation and social media.

_____ _____

Client or Parent/Guardian Signature Date

_____ _____

Client or Parent/Guardian Signature Date

_____ _____

Laura McCarthy, PhD, LMFT Date

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INSURANCE/THIRD PARTY PAYER BILLING CONSENT
(If applicable—This form is not needed for self-pay clients)

Name of Health Insurance Plan (or other Third Party Payer): _____

I, _____, authorize Laura McCarthy, PhD, LMFT to release my (or my child's) psychotherapy records as needed to a third party payer (Insurance Company, EAP, or another third party payer source), for the purpose of payment or authorization of treatment. This information may include status of attendance in therapy, diagnosis, treatment plans, discharge plan, or other records required by the third party payer for payment or service authorization. This authorization will apply to other health insurance plans or third party payers if my coverage changes in the future and/or I request claims to be billed to another plan/payer.

This authorization also includes releasing information to a confidential medical billing service for the purpose of submitting claims and obtaining payment from the health insurance plan or other third party payer.

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MISSED APPOINTMENT/LATE CANCELLATIONS CHARGES

By signing below, I acknowledge that I am responsible for payment of charges by Laura McCarthy, PhD, LMFT for missing an appointment without at least 24-hour notice of cancellation. I acknowledge that the amount for which I am responsible in the event of a late-canceled or missed appointment is $50.00. I agree to pay this amount within 30 days of my late-canceled or missed appointment. I understand that my health insurance will not be responsible for payment of any missed appointments.

(Note: I understand that emergencies, bad weather, and illness do have the potential to interfere with our scheduled appointments. It is my policy to allow for one missed appointment or late cancellation without charge. After the first missed session, I must request the missed appointment/late cancellation fee. Please be especially mindful if you have scheduled an appointment during my most-requested appointment times: mornings before 9:30am, afternoons/evenings after 3:00pm, or any weekend appointments. These are times where cancellations have the most impact on my ability to serve other clients. Thank you for your consideration in this matter!)

Would you like to receive text message reminders of your appointments, sent the day before our session?

- ☐ Yes, at this phone number:_____
- ☐ No

_____ _____
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_____ _____
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Client Name:_____ Date of Birth:_____ Gender: _____

Nick name, or prefer to be called:_____

Street Address:_____ City/State/Zip:_____

(Please circle or star your preferred phone number)

Home Phone:_____ Messages okay? Y or N

Cell/Other Phone:_____ Messages okay? Y or N Text okay? Y or N

Email address:_____ Ok to send email? Y or N

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone Numbers:_____

Marital Status: ☐ Never Married ☐ Married (# of yrs _____) ☐ Committed Relationship ☐ Separated ☐ Divorced ☐ Widowed

Occupation:_____

Please check any current symptoms you are experiencing:

____Depression/Sadness	____Isolation/Withdrawal	____Suicidal Thoughts
____Anger/Irritability	____Homicidal Thoughts	____Self-Harm/Injury, Cutting, Etc.
____Appetite Problems	____Financial Problems	____Anxiety, Panic, Worry, or Phobia
____Sleep Disturbance	____Difficulty Expressing Feelings	____Obsessions and/or Compulsions
____Aggression/Violence	____Victim of Abuse	____Low Self-Esteem/Confidence
____Domestic Violence	____Perpetrator of Abuse	____Problems Thinking/Concentrating
____Relationship Conflicts	____Addictive Behavior	____Pronounced Mood Swings
____Workplace/School Stress	____Alcohol/Substance Abuse	____Stress/Feeling Overwhelmed
____Communication/Trust Problems	____Grief/Loss	____Legal Problems
____Chronic Medical Problems	____Parenting Issues	____Religious/Spiritual Issues
____Binging/Purging/Anorexia	____Sexual/Intimacy Issues	____Questioning of Sexual-Orientation/Gender

Indicate any current medications related to mental health/behavioral health (e.g., anti-depressants, anti-anxiety, sleep medications, Antabuse, etc.):_____

Name and phone number of prescribing professional:_____

If not on medication, is a referral for a medication-evaluation needed? Yes No Maybe

Please list any current physical health concerns:_____

_____

Please list past and present tobacco, alcohol, and drug use:_____

_____

Who referred you to see me?_____ (e.g., friend, name of doctor, name of website, etc.)

What concern brings you in? What goals do you hope to achieve through counseling? _____

_____

_____

_____

Have you participated in therapy before? If so, what was helpful and/or unhelpful about the experience? If not, what are your hopes and/or reservations about therapy? _____

_____

_____

_____

How do you feel our therapy together can be most helpful? Do you have thoughts or preferences about how you would like therapy to proceed? _____

_____

_____

_____

Thank you for taking the time to complete this information!

Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	2. Feeling down, depressed, or hopeless?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
III.	4. Sleeping less than usual, but still have a lot of energy?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	5. Starting lots more projects than usual or doing more risky things than usual?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	7. Feeling panic or being frightened?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	8. Avoiding situations that make you anxious?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	10. Feeling that your illnesses are not being taken seriously enough?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
VI.	11. Thoughts of actually hurting yourself?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
XII.	19. Not knowing who you really are or what you want out of life?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	20. Not feeling close to other people or enjoying your relationships with them?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	

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SAFETY ASSESSMENT

The following questions provide an initial assessment of potential safety concerns, which allows me to be more fully aware of and responsive to your therapeutic needs. Please feel free to ask me if you have any questions about how the information provided will be used in treatment. (If client is a minor, parents should assist the child in completing this form.)

- Recent thoughts of suicide Yes❑ No❑
- Suicide attempt or suicidal actions in the past Yes❑ No❑
- Thoughts of being better off dead Yes❑ No❑
- Recently feeling hopeless about life or problems Yes❑ No❑
- Feeling no one cares Yes❑ No❑
- Struggling with alcohol or drug use Yes❑ No❑
- Past hospitalization for mental health or drug/alcohol concerns Yes❑ No❑
- Is anyone in your home being hit, pushed, slapped, etc.? Yes❑ No❑
- Is anyone in your home being threatened? Yes❑ No❑
- Are firearms kept in your home? Yes❑ No❑
    - If yes, how are they kept secure? _____

Comments (optional):