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

DISCLOSURE, TREATMENT, AND FEE AGREEMENT—"VALUED RELATIONSHIPS"

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: "Valued Relationships" is a relational healing program designed by Laura McCarthy, PhD, LMFT, focused on changing relationship patterns, healing communication, and building loving connection. 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: The typical length of the "Valued Relationships" program ranges from 4 to 6 months of bimonthly 90-minute therapy sessions as well as recommended readings and out-of-session exercises. The exact length of the program is determined by ongoing evaluation in consultation with the couple. The fee for this program is $225 per 90-minute session. This program is a private pay service only and cannot be billed through a third party, such as your medical insurance. If at any time during this program you wish to seek a referral for couples counseling paid through insurance, a referral will be made. You will be billed $100 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.

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 business day.

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 Signature Date

_____ _____
Client Signature Date

_____ _____
Laura McCarthy, PhD, LMFT Date

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CONFIDENTIALITY IN COUPLES AND FAMILY THERAPY

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure**.** Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me 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 unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____(couple/family or other unit being seen), acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Laura McCarthy, PhD, LMFT, and that we enter couple/family therapy in agreement with this policy.

_____ _____
Client Signature Date

_____ _____
Client Signature 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

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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

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Client or Parent/Guardian Signature Date

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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!

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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
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_____

_____

_____

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!

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SAFETY ASSESSMENT

Name:_____

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):

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Name:_____

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- 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):