DISCLOSURE STATEMENT

422 E. Vermijo Ave. Suite 211
Colorado Springs Co 80903
(719) 231-8746

1. Credentials:
I am a Registered Psychotherapist (NLC.0012939) in the State of Colorado, I hold a Masters of Science in Marriage Family Child Therapy from University of Phoenix. I earned a Bachelor of Science in Human Services from University of Phoenix. I am an Eye Movement Desensitization and Reprocessing (EMDR) Provider. I am a Certified Neuro Linguistic Programmer (NLP) Practitioner. I have worked as a Mental Health Provider for several clinical type settings.

2. Regulations of a Psychotherapist

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 a 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.

3. CLIENT RIGHTS AND IMPORTANT INFORMATION

1. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and fee. Please ask if you would like to receive this information.
2. You can seek a second opinion from another therapist or terminate therapy, at any time.
3. 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 board that licenses, certifies or registers the therapist.
4. 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.

4. CONFIDENTIALITY

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. **(6)**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 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. **Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process and so may wish to allow confidentiality between the child and therapist**. **(7)**Disclosure may be required pursuant to legal proceedings. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy records and/or testimony by your therapist. If you are on probation/parole, it may be legally required that I share information with individuals appointed by the court.

In addition to the circumstances where disclosure is required by law, you authorize me, at my sole discretion, to report to appropriate protective and/or law enforcement agencies if I suspect the mistreatment, abuse, or neglect of animals.

5. CONSULTATION, VIEDO AND AUDIO RECORDING OF SESSIONS: In order to provide the best possible therapy treatment, it is common for therapist to record video of therapy sessions. The purpose of recording therapy session is to enhance the effectiveness of therapy by providing me with a way to review your therapy sessions. I also consult regularly with other professionals (all of whom are bound by confidentiality laws) concerning our respective clients, and this consultation sometimes includes reviewing recorded portions of therapy sessions. By signing this Disclosure Statement below you consent to allow your therapy sessions to be recorded by audio and/or video; you give permission to, at my sole discretion, review the recordings with my professional colleagues; you acknowledge you understanding that you may withdraw this consent for your sessions to be recorded at any time by providing written notice to me; you acknowledge your understanding that copies of audio/video recordings are **not** kept as part of the clinical record; and you acknowledge that you have had an opportunity to ask questions and that your questions have been answered satisfactorily.

POLICIES SPECIFIC TO MY PRACTICE

a. 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 you 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.
b. Robert Crouse Family Therapist LLC. is not a crisis center. I am not trained specifically for crisis intervention. If you have a life threatening emergency you should not contact me. Instead you should call 911, or go to the nearest emergency room INITIALS ________________

c. I sometimes consult with other professionals regarding my therapy clients as this is a best practice in the field of psychotherapy. Any professionals with whom I consult will be held to the same confidentiality requirements as I am. Your signature on this Disclosure Statement gives me permission to consult with other professionals about your case at my sole discretion.

d. Payment and Fees: For the purpose of calculating the fee for a session, there is a minimum charge of 50 minutes for any session, regardless of its actual length.

Robert Crouse Family Therapy LLC. operates on a sliding scale (Based on household income). For any session that starts after 9 AM and ends before 8 PM on non-holiday weekdays and Saturdays, the fee for a 50 minute session will be between $65.00 and $95.00. The fee for additional time will be $25.00 for every 10 minutes (round up to the next 10minutes). Robert Crouse Family Therapy LLC. also provides financial assistance for families that qualify (ask to see if you qualify).

For any telephone calls, except for telephone calls related only to scheduling appointments, there is a fee of $35.00 per 10 minutes (rounded up to the next 10 minutes), which will be charged to your credit card on file after the call is complete.

A **discount of $5.00 will be made for payments made by cash.** Acceptable forms of payment are cash, check, or debit/credit card. If your check is deposited with insufficient funds your credit card on file will be charged for the amount of the bounced check plus an additional $35.00 to cover the bank and processing fees. Payment is due at each session unless other arrangements have been made. **Fees outlined above are subject to change at any time, and will likely go up every February 1st.**

e. Overdue Payment: If your account is more than 30 days overdue and suitable arrangements have not been agreed to, I have the options of suing legal means to secure payment, including collection agencies or small claims court, and you agree that I may disclose your personal information as needed for the purpose of collecting outstanding balances. You will be responsible for any and all legal or collection costs I incur in my attempts to collect any outstanding balance.

f. Third Party Payments (by Clergy, other family member, or friend): When a third party offer to pay, in full or in part, for services you receive at Robert Crouse Family Therapy LLC. , you may be asked to make a copayment at the time of each session. If this third party does not pay for any reason, you will remain personally responsible for the full fee.

g. Cancellation, No-Shows, and Credit Card: **A minimum of 24 hours** is Required Notice for rescheduling or canceling and appointment that is scheduled for 50 minutes or less. A "Late Cancellation Charge", of the full scheduled appointment, will be charged to your credit card on file if you have not showed up or called within 15 minutes of the scheduled start of the session and/or any session which you cancel or reschedule with less than the Required Notice, such notice to be provided by leaving a voice message or text at (719) 231-8746, or by sending an email to healing@robertcrousetherapy.com **(Please note that if a couple or family session is scheduled, we will not start the session until ALL individuals scheduled for that session show up. If you substitute and individual session with a couples or family session an additional $10.00 will be charged.)** In the event that a Late Cancellation Charge is due, or if a check is deposited with insufficient funds, or if full payment is not made at the time of the session, you hereby authorize me to charge your credit card on file for the full amount due, or it we have no valid credit card information for you on file, you hereby authorize me to charge the following credit card for the full amount due and to place this card on file:

Credit Card Number: ____

Expiration Date: ______________________ CVV: ____________________

Name as it appears on card: ______________________________________

Signature of Cardholder: ____

h. Email, Social Networking, and Internet Based Services Policy: Because it is not possible to guarantee the confidentiality of email communications, neither Robert Crouse Family Therapy LLC. nor I personally can be held responsible for any information viewed by a third party. Email should only be used for brief, general questions. Hence emergencies, therapeutic issues, and sensitive personal information should be communicated over the telephone or in person. By signing below you authorize me to communicate with you via email for the purposes of scheduling sessions and you authorize me to utilize internet based scheduling services and internet based survey services, and provide such services with you name and contact information, for the purposes of scheduling sessions and for the purposes of gathering feedback from you in the form of internet communication and surveys regarding your experiences in therapy INITIALS ____________________________

i. Any court appearances (including any time I spend preparing for court appearance and travel and waiting time associated with the court appearance) as well as any time I spent writing or preparing reports for you or any third party regarding your therapy, will be billed ($150.00 for Court appearances and $50.00 for every 30 minutes after the first 1 hour, For letters to the Court $30.00, For preparing a diagnosis and assessments between $150.00 - $200.00) against a retainer of not less than $2500.00 payable to Robert Crouse Family Therapy LLC. by you in advance of my beginning any work.

6. SECRETS POLICY

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

During the course of my work with a couple or a family, I may see a smaller part of the Treatment Unit / Family System (e.g., and individual, a parent/child, or siblings) for one or more sessions, and I may communicate with individual members of the Treatment Unit / Family System via phone, email, tec. By signing this Disclosure Statement below, you agree that these sessions and communications are conducted as a part of the work that I am doing with the Treatment Unit / Family System; that based solely on my judgment, I may determine a need to share with other members of the Treatment Unit / Family System the information disclosed to me in these sessions and communications; and that I may use my best judgment to determine whether, when, in what manner, and to what extent I will disclose such information to other members of the Treatment Unit / Family System. This secrets policy is intended to allow me to continue to treat the Treatment Unit / Family System by preventing, to the extent possible, a conflict of interest to arise where an individual's interest may be consistent with the interest of the Treatment Unit / Family System (for example, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or 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 reduce the risk that such a termination might be necessary). Because you are explicitly agreeing that I may share with other members of the Treatment Unit / Family System, you are encouraged to consult with and individual therapist. You acknowledge by your individual signature on this Disclosure Agreement below that you read and understand this secrets policy, and that you enter therapy as a member of the Treatment Unit / Family System that includes all the individuals who sign this Disclosure Statement below. INITIALS ________________________________

Counterparts/Execution. This Disclosure Statement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Signature pages may be executed via "wet" signature or electronic mark and the executed signature pages may be delivered using pdf or similar file type transmitted via electronic mail, cloud based server, e-signature technology or other similar electronic means.

By signing below you acknowledge that you have read, understand, and agree to the provisions contained in this Disclosure Statement; that you have received a copy of this Disclosure Statement; that the information has been presented to you verbally; that you understand the disclosure that have been made to you; that you enter therapy as a member of the Treatment Unit / Family System that includes signing this Disclosure Statement; and that you acknowledge your understanding that results of therapy cannot be guaranteed and that, no warranty is given, implied, or expressed.

_________________________ _________________________ Date: __________

Print Client's Name Client Signature or Responsible Party

DOB: _________________________ Print : _________________________

If signed by the Responsible Party, Identify that party's legal authority to consent to treatment:_________________________

_________________________ _________________________ Date: __________

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