

Jennifer Webb, MA
Seasons Counseling Center, LLC
503 Remington St. Fort Collins, CO 80527 (Location)
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970-222-7820

DISCLOSURE STATEMENT

The following are rights that all persons receiving mental health care have. They are important for you to understand and will be reviewed with you along with an opportunity for you to ask any questions you may have regarding them.

1. The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies. Questions and complaints may be addressed to the Grievance Board: Department of Regulatory Agencies, Mental Health Section, 1560 Broadway Suite 1350, Denver, CO 80202, (303)-894-7766

2. You have the right to be informed of your therapist's degrees, credentials and licenses.

Jennifer holds a Master's Degree in Counseling with a Biblical Emphasis from Colorado Christian University. She completed her Master's program in early May, 2008. Her undergraduate degree was a Bachelor's in Environmental Health with a Major in Health Sciences and a Minor in Psychology from Purdue University in 1999. Jennifer has specific education regarding Christian Theology and integrating faith into counseling as clients wish. Her supervised experience includes work with individuals struggling with a variety of serious mental health and addiction issues as well as suicidal ideation. She is pursuing licensure in the state of Colorado and is currently active on the state database.

3. You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.

Counseling Orientation: I offer an expertise in integrating Christian truths into the therapeutic process. I am trained in Christian Counseling, and offer this orientation to those who wish to receive it. I am also sensitive to the client's right to choose the level of interest in this approach, and am happy to offer professional psychotherapy without this spiritual emphasis. Please note whether you wish to receive _____ or do not wish to receive _____ a Christian orientation in your professional counseling. Please initial _____.

4. You may seek a second opinion from another therapist at any time. You may also terminate your therapy with me at any time.
5. In a professional relationship, sexual intimacy is never appropriate and is illegal in Colorado. It should be reported to the Colorado Grievance Board. (See #1).

6. The information you provide during therapy sessions is legally confidential. What this means is that for whatever reason I was subpoenaed into court to testify regarding a matter for which you would be before the court, I could not be compelled to testify against your wishes. There are two exceptions to this:
- a) If you present a danger to yourself or others, (suicide, homicide, AIDS/HIV), your therapist will need to make arrangements to keep you safe. This may include communicating with other medical professionals or law enforcement agencies.
 - b) If you disclose that a child or elderly person is being abused, all therapists are required by law to report that abuse to Social Services.

OFFICE POLICIES

Hours: Office hours and counseling sessions are by appointment only. Based on the nature of my practice, I am unable to provide counseling services to clients who require 24-hour care. I do not carry a pager. However, I check my confidential voicemail several times per day and strive to return phone calls within 24 hours. Calls made over the weekend will be returned on Monday (unless I am on vacation). If you have a counseling emergency and I am not available, please go to the nearest emergency room, contact the police or dial 911.

Emergencies: The practice of private outpatient psychotherapy with adults makes the assumption that clients are functioning, self-responsible individuals with legitimate concerns, needs and pain. Private outpatient psychotherapy cannot, by its structure, assume responsibility for day-to-day functioning of its clients in the same way agencies and inpatient institutions can. At times, however, some clients may require special attention or assistance. I do not carry a pager and am not ordinarily available for therapy or crisis calls apart from our scheduled appointments. I will, however, consider exceptions to this policy as the appropriate need arises.

Records: Records are safely stored with attention to your privacy for at least 10 years, as required by Colorado Statute. They will only be released with your written permission and direction. If you were seen in a Couple's or Family Session, all adults present would have to authorize the release of that record. You will be granted reasonable access to your records. If you choose to read your records, it is my policy to be present in order to respond to any questions or confusion you may encounter about the contents.

Court Proceedings: I am unwilling to be a witness in any child custody, divorce, or any other domestic, civil, or criminal court proceedings.

Appointments: I understand that at times it may be necessary to cancel an appointment. If you are unable to keep a scheduled appointment, you must notify the office 24 hours ahead of time in order to avoid being charged the full fee for the time. Be aware that

insurance will not cover missed appointments, so the obligation to pay is yours. Except in the event of emergencies and other extenuating circumstances, the full fee will be charged for missed sessions. *In the same way, because your time is as valuable as mine, should I ever miss a scheduled appointment with you without any notice, I will provide the subsequent session at no charge.*

Fees and Insurance: The hourly fee for a 50-minute session is \$80.00. *Payment is expected at the time of service. Any non-payment will be turned over to a collection agency.* Many insurance policies provide at least partial coverage for counseling services, however, in order to receive reimbursement, health insurance companies require that I diagnose the issues for which you are coming to counseling by indicating that you have a “psychological disorder” or “mental illness” which will remain part of your permanent records. Therefore, for professional and ethical reasons, it is my policy to not serve as an insurance healthcare provider.

As a client, (or parent/guardian), I have read and understood, or asked for clarification about, the information and policies presented in this form. I consent to receiving (or my child receiving) counseling services under these conditions.

Client Signature _____ Date _____

Printed Name _____

Parent/Guardian Signature _____ Date _____
(If client is under 18 yrs of age)

Therapist
Signature _____ Date _____

In addition, I hereby acknowledge that I have received a copy of the Provider’s Disclosure Statement, Office Policies and Client’s Rights.

Client Financial Agreement:

I accept responsibility for the payment of all charges under the above terms. I understand that if my account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, then legal means may be used to secure the payment. This may involve utilizing a collection agency or going through small claims court. I hereby authorize the provider to release any information required to process claims for services or to obtain payment for services.

Client Signature _____ Date _____