Craig D. Lounsbrough, M.Div., LPC
Licensed Professional Counselor
19284 Cottonwood Drive, Suite 202
Parker, Colorado 80138
(303) 593-0575

DISCLOSURE AND CONSENT FORM

Welcome to my practice. Thank you for deciding to seek counseling with me. The following information will help you understand many of the details about your therapy here. My primary commitment is to provide quality treatment to individuals, couples and families regardless of age, race, gender, or religious affiliation. Professional Christian counseling and the use of spiritual resources are available for patients who request it. I am further committed to the patient's rights of information regarding office policy, non-discrimination, confidentiality, consent and competent service. In keeping with this policy, I have listed below several regulations, client rights, divorce, custody, professional and my office policies for your information. Please read through these, ask any questions you may have. Also, please read through and sign the other forms provided along with this disclosure form. Please ask me any questions you have regarding these forms or their content during our session (s).

Many of my patients have already seen my website, www.craiglpc.com and read my biography regarding my professional experience and credentials. I have also included a copy in your intake packet. Please initial here that you are aware of this information and _____/_____please ask me any questions or concerns you may have during our session (s).

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 master's 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 bachelor's 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 master's 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.

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 my 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. Consistent with my established moral and ethical position, 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. 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; (5) I am required to report abuse of a senior, who is 70 years of age or older, which I believe has probably occurred, including institutional neglect, physical injury, financial exploitation, or unreasonable restraint; and (6) I may be required by Court Order to disclose treatment information.
5. 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 concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.
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 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.
7. I agree not to record our sessions without your written consent; and you agree not to record a session or a conversation with me either through voice or video recording without my written consent.
8. Have you ever filed a grievance on a mental health, medical or dental professional? Yes / No
   If yes, please explain the situation and outcome to Mr. Lounsbrough during your initial session.

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.

PAYMENT POLICY

My policy is for each person receiving counseling or testing services to pay for such service **at the time the professional services are rendered**. Payment can be made using cash, checks, or Visa/MasterCard. Any other arrangements **must be made in advance**. **A $35 administrative fee will be charged on all checks that are returned for non-sufficient funds.**

My per-session fee is **$130** and is based on a fifty (50) minute session. Weekend appointment fees are **$130** per each fifty (50) minute session. Patient telephone calls, consultations with other professionals, and report preparation less than 5 minutes are without charge; those 5 minutes or more are billed at the per session rate in 15 minute increments.

Please note: Charges for testing services are in addition to the regular per-session fee. Please refer to the assessment policy sheet for further information.

INSURANCE
Many insurance policies provide partial to total coverage for mental health services. Your insurance (personal, group, private, governmental, partial payment or full payment type) is a contract between you and your insurance company; it is not an agreement between the insurer and my practice. This means that your account with me is **your responsibility** regardless of insurance coverage which may exist. It is agreed that payments will not be delayed or withheld because of any insurance coverage or dependency upon those payments. It is also understood that Craig D. Lounsbrough, LPC will not assume responsibility for the collection of insurance payments. I (we) authorize the release of my DSM-V (or ICD-10) diagnosis to be printed on my (our) HCFA (Health Claim Form) in order for me (us) to obtain any and all ***out of network*** insurance benefits.

CANCELLATIONS/MISSED APPOINTMENT
I understand that it may, at times, be necessary to cancel an appointment. To help me be most efficient and responsible in the use of my time, I require that **any changes or cancellations be made at least 24 hours in advance any work day, Monday through Friday**. If there is a need to cancel a Monday appointment, that cancellation would need to be made **by the Friday before the appointment**. If you have scheduled two fifty-minute sessions on the same day and need to cancel, I will need **48 hours advance notice**. **Any changes or cancellations received less than 24/48 hours in advance <u>will</u> be charged the regular per-session rate. Any missed appointment with no call received will be charged the regular per-session rate**.

EMERGENCIES
If a <u>life threatening</u> emergency arises, please call 911 or go to your nearest hospital emergency room. Please let them know you are one of my patients and ask them to call me. I would also ask that you call me as soon as you are able.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT
I authorize treatment of the person named below and agree to pay all fees for such treatment. I agree to pay all charges for me and members of my family shown by statements promptly, upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. Accounts with no financial activity for 30 days may be sent to a professional collection agency, including potential court costs, attorney fees, and other costs of collection.

I attest that I have read this information sheet and that it has been presented to me verbally. I have seen Craig Lounsbrough's biography, am aware of his degrees, and credentials, professional experience and certifications. I understand the disclosures that have been presented to me. I further agree to receive counseling under these conditions and that I have received a copy of this Disclosure Statement.

_____ _____
Signature of Patient or Legal Guardian Signature of Spouse (when in Couples Therapy)

Print Client's Name _____ Print Client's Name _____

Date: _____ Date: _____