LOVING FAMILIES, PLLC

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DISCLOSURE STATEMENT & POLICIES

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. LOVING FAMILIES, PLLC is located at 609 West Littleton Blvd., Suite 309, Littleton, Colorado 80120. The mental health professional located at LOVING FAMILIES, PLLC is Amy M. Craig, MA, LPC. Amy graduated with a Master's of Counseling degree from Denver Seminary in 2004. She is a Licensed Professional Counselor with the State of Colorado, License #LPC 4500.

2. Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for their minor child/ren, must sign this disclosure statement on behalf of their minor child under the age of fifteen (15) years old. This disclosure statement contains the policies and procedures of LOVING FAMILIES, PLLC and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal Regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

3. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through LOVING FAMILIES, PLLC's internal process.

4. You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing, and given to your therapist, at any time during therapy.

5. Levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. Licensed Social Worker must hold a masters degree in social work. 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. 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. Registered Psychotherapist is a psychotherapist listed in Colorado'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. Registered psychotherapists are required to take the jurisprudence exam.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

As a client you are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information.

Fees:
1. My fee structure, services, and fee policy provided are outlined as follows:

a. $110.00 per hour

b. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement in writing. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

c. Therapy fees and treatment are based on a 45-50 minute clinical hour instead of a 60 minute clock hour so that I may review my notes and assessments on your behalf.

d. I am a Medicaid provider. I am currently only a provider with Behavioral Healthcare, Inc. (BHI). If you have Medicaid coverage that includes mental health services with BHI, I am able to offer mental health services to you. Otherwise, I am not able to offer mental health services to you.

e. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $300.00 per hour.

Restrictions on Uses:
2. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however LOVING FAMILIES, PLLC is not required to agree to a restriction request. Please review LOVING FAMILIES, PLLC's Notice of Privacy Policies for more information.

Second Opinion and Termination:
3. You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

Sexual Intimacy:
4. In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291 (303) 894-7800; DORA_MentalHealthBoard@state.co.us, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Licensed Professional Counselor Examiners

Confidentiality:
5. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, or a Registered Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

6. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

7. Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out LOVING FAMILIES, PLLC's Consent for Communication of Protected Health Information by Unsecure Transmissions.

Extraordinary Events:
8. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

Stephenie Combs, MA, LPC #6131
Blue Sky Counseling
7955 East Arapahoe Ct.
Suite 1400
Centennial, CO 80112
720-437-9665

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Electronic Records:
9. LOVING FAMILIES, PLLC may keep and store information for each client electronically on LOVING FAMILIES, PLLC's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect the record, LOVING FAMILIES, PLLC may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. LOVING FAMILIES, PLLC may also be able to remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

LOVING FAMILIES, PLLC utilizes "TherapyAppointment" for scheduling purposes, Office Ally for some record storage, Google Business for email, and Google Voice for client contact and scheduling. She may also use electronic backup systems either by using external hard drives, thumb drives, similar methods, or through a cloud-based service. This helps prevent the loss or damage of electronically stored information. LOVING FAMILIES, PLLC maintains the security of the electronically stored information through encryption and passwords. The cloud-based backup means that the information is stored on computers which are connected to the internet. In order to maintain security of the information LOVING FAMILIES, PLLC has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with TherapyAppointments, Google Business, and Office Ally. Because of this Agreement, these companies are obligated by federal law to protect the information from unauthorized use or disclosure.
- These companies employ various security measures to maintain the protection of the information from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the information, such as the company's workforce in order to maintain the system itself. Federal law protecting the information extends to these workforce members. If you have any questions about the security measures LOVING FAMILIES, PLLC employs, please ask.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that LOVING FAMILIES, PLLC may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with LOVING FAMILIES, PLLC's Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in LOVING FAMILIES, PLLC's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.

3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides an attorney retained by my therapist.

4. I understand that, in general, LOVING FAMILIES, PLLC does not provide Teletherapy, such as therapy over telephone or video chat. I understand that communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. I understand that should I want Teletherapy, I will discuss my request with my therapist. I understand that it is in my therapist's sole discretion whether to accommodate my request for Teletherapy.

5. I understand that my therapist, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that LOVING FAMILIES, PLLC has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" LOVING FAMILIES, PLLC's business social media page that others will see my LOVING FAMILIES, PLLC associated with "liking" or "following" that page. I understand that this applies to any comments that I post on LOVING FAMILIES, PLLC's page/wall as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and **not** through social media.

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

7. I understand my therapist provides non-emergency therapeutic services **by scheduled appointment only**. If, for any reason, I am unable to contact my therapist by telephone number she provided me, **720-515-9180**, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. LOVING FAMILIES, PLLC does not provide after hours service without an appointment. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due**. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call by the end of the next business day, excluding holidays and weekends.

8. If my therapist believes my therapeutic issues are above her level of competence or outside of her scope of practice, she is legally required to refer, terminate, or consult.

9. **I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payor, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payor, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance company receives the information I or my therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report LOVING FAMILIES, PLLC submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.**

10. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Authorizations for release and consent for treatment will be revoked one year after the signing date, unless otherwise specified. I understand and acknowledge receipt of LOVING FAMILIES, PLLC's Notice of Privacy Policies and Practices.

11. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to sign a separate Consent for Third-Party Participation Agreement or may have to sign a separate disclosure statement in order to

participate in therapy.

12. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with LOVING FAMILIES, PLLC or my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with LOVING FAMILIES, PLLC. Ability to resume therapy after sixty (60) days will depend upon my therapist's availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least sixty (60) days, unless otherwise agreed to in writing.

13. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

14. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of psychotherapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling), cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to her relatives, friends, the relatives of friends, people she knows socially, or business contacts.

15. **I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.**

16. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services here at LOVING FAMILIES, PLLC or that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15), for whom I am requesting therapy services here at LOVING FAMILIES, PLLC.

17**. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist requires that I produce the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.**

18. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that LOVING FAMILIES, PLLC is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

____ _______________
Client Name/Signature DATE

____ _______________
Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

____ _______________
Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

____ _______________
Therapist Signature DATE