Marilee Boe M.A.
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Professional Disclosure Statement

Welcome to my psychotherapy practice. I look forward to collaborating with you to reach your therapy goals. I earned a Master of Arts Degree in Guidance and Counseling from the University of Northern Colorado in 1982. I am a Licensed Professional Counselor (#632) in the state of Colorado. My philosophy towards working with clients tends to be Cognitive Behavioral in nature. Cognitive Behavioral Therapy (CBT) focuses on the way we think and how our thinking affects our behavior and our moods. Much of the way we think is formed when we are kids, hence, I will ask some questions about your family of origin. In general, treatment goals will be established after a through assessment. You will take an active role in setting and accomplishing your treatment goals. Homework assignments and practicing new ways of behaving is standard practice. Your commitment is paramount in creating change. I also employ other therapy styles, depending on the needs of each client(s). Please feel free to ask questions about your treatment at any time.

Client Rights and Responsibilities

If you choose to use your insurance it is your responsibility to obtain prior authorization for your treatment. It is necessary for you to understand your insurance plan and its regulations. You are responsible for any deductibles, co-payment, and any unpaid balances. If there is an ongoing unpaid balance, I reserve the right to turn your account over for collection.

~My standard fee is $150 for an assessment and $130 for usual :50 minute sessions. Fees/co-payments are due at the beginning of your appointment. I accept cash, checks, credit cards, and HSA cards.

-My fee for writing letters, reports, faxing documents is $50 per quarter hour.

-Occasionally a client may want my participation in legal action. Or, I may be served with a subpoena, or be ordered to testify. My fee for all

court related activities is billed at the rate of $200/hour, "door to door". This includes setting any time aside for court related activities. This can include and not be limited to: writing or rewriting letters, reports, testifying, travel, copying/faxing files, research, waiting.

~You are entitled to receive information from me about my methods of therapy, techniques I use, the duration of your therapy (if it can be determined) at any time.

~Scheduled appointments are reserved especially for you. I request 24-hour notice of cancellation: otherwise insurance clients may be charged a $100 fee. Private pay clients may pay my full fee of $130. A "no show" appointment is charged my full fee of $93-$130. Repeat no show appointments will likely result in a termination of treatment and referral to another provider or your managed care company.

*****_____ clients initials**

~You can seek a second opinion from another therapist or terminate therapy at any time.

~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 Mental Health Licensing Section of the Division of Registrations. The Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Co. 80202, 303-894-7800.

Confidentiality

-Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released with out the client's consent. there are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes,
~The information you discuss with me is protected as confidential under state and federal law with some limitations (imminent suicide/homicide risk, child/elder abuse).
~If you choose to use your health plan, they may require some information from me to obtain authorizations or payment.
~If you file for disability benefits, your entire record may be requested to help with the determination of your case.
~If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality will be waived.

~I may feel it necessary to consult about your case with another mental health professional. Your identity will not be revealed without your consent. The individual with whom I consult will protect your privacy.
~I utilize individuals for billing assistance. They are given very limited information and are prohibited from re-disclosing information
~"When I take occasional leave from work, I will inform you two weeks ahead of time, if possible. A colleague will be available for emergent problems. You will be provided with this information and it will be available on my voice mail.
~You are responsible for the understanding of fees and costs when you are beyond or outside of your insurance benefits.
~At any time in treatment should you become ineligible for insurance, you will notify me and understand that you will be responsible for 100% of the bill.
Please reverence the website listed below to reference HIPPA Notice of Privacy Rights:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html

Electronic communication can be efficient means to share information with me. It is important that you understand email can be hacked or breached in some form or fashion. If you choose to communicate with me via email or text message, it is understood that I have permission from you, to respond in the same manner. Telephone calls are always the best way to reach me.

Records

Colorado statute requires me to store your records safely for a period for up to 7 years. For your records to be released to anyone, it requires your signed consent, the reason they are being released, and to whom. In order to revoke a consent it requires your signature. If you were seen in a couples or family session, a release would require both adults to consent.

Consent to Treatment

I authorize and request Marilee Boe, M.A., L.P.C. to carry out assessment and treatment procedures that now, or during the course of my treatment, become advisable. I understand the purposes of the procedures will be explained to me upon my request and they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, Marilee Boe can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and sensations. I understand that this is a normal re-

sponse to working through unresolved life experiences and that Marilee Boe and I will address these reactions.

General Consent for Child or Dependent Treatment

I am the legal guardian(s) or legal representative of the patient and on the patient's behalf legally authorize Marilee Boe, M.A., L.P.C. to deliver mental health care services to the client. If the parents are divorced, and custody is shared, both parents must sign the Disclosure Statement. I understand that my child, if 14 years old or older, is entitled to a confidential relationship with Marilee Boe, M.A., L.P.C.. I also understand that all policies described in this statement apply to the patient I represent.

Termination

Termination will usually be agreed upon mutually, but you are free to terminate treatment at any time. However, in rare circumstances I may decide to stop working with you even if you may wish to continue. These may include; failure to meet the terms of our fee agreement, a need for special services outside the area of my expertise, and/or failure to progress toward treatment goals. Should any of these circumstances occur, the reason for termination will be discussed with you, and you will be assisted to towards making different plans for your care and treatment. This may include a referral to another care provider.

I have been informed of my therapist's degrees, credentials, and licenses. I have also read the preceding information and understand my rights and responsibilities as a client.

_____ _____

Print Client Name **Witness Signature**

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Client or Responsible Party Signature

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Date