

## **DISCLOSURE, TREATMENT, AND FEE AGREEMENT**

**Mary Costello Stevens, LPC  
6021 S. Syracuse Way, Suite 111  
Greenwood Village, Colorado 80111  
Phone: 303-380-7070**

### **Degrees and Credentials**

Bachelor of Arts in Psychology (2002)  
Master of Arts in Professional Counseling,  
Specializing in Marriage and Family Therapy (2007)  
Licensed Professional Counselor (LPC) in Colorado #5844 (2010)

### **Therapy Services**

It can be difficult to describe therapy in general statements, as it varies based on the personalities of the therapist and client and the issues that you hope to address. Therapy is not like a medical doctor visit and instead calls for you to be an active participant in the process, both in sessions and between sessions.

Therapy can have benefits and risks. Therapy often involves discussing difficult topics and can bring up feelings of sadness, anger, guilt, or hopelessness. However, therapy often has benefits to the people who experience it and may lead to better relationships, solutions to specific problems, and reductions in negative feelings. There is no guarantee that therapy will yield positive results. Every effort will be made to provide you with a positive and healing experience, but every therapy experience is unique and varies among individuals.

If you ever have questions or concerns about the therapy work we are doing, please feel free to discuss those with me. If we determine that you are not benefitting from therapy or need a different level of care, I will help you in finding appropriate referral resources.

### **Regulatory Requirements Applicable to Mental Health Professionals**

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 Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors and can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

Levels of regulations of mental health professionals in Colorado include licensing (requires minimum education, experience, and examination qualifications), certification (requires minimum training, experience, and for certain levels, examination qualifications), and registration (does not require minimum education, experience, or training.) All levels of regulation require passing a jurisprudence take-home examination.

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 Master's degree in their profession and have two years of post-Master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-Doctoral 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 Technician must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or an equivalent exam, and complete 1,000 hours of supervised experience. A Certified Addiction Specialist must have a bachelor's degree in behavioral health, complete additional required training hours, pass the National Addiction Exam, Level II or an equivalent exam and complete 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's or doctorate degree, pass the Master Addiction Counselor Exam or an equivalent exam, and complete 3,000 of supervised experience." An Unlicensed 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**

*Method of Treatment:* You may receive information about my methods of treatment, techniques used, duration of therapy if known, and the fee structure. At any time, you may seek a second opinion or terminate treatment. Please be advised that in a professional relationship (such as ours), sexual intimacy is never appropriate and should be reported to the board that licenses, certifies or registers the therapist.

*Sessions and Fees:* Sessions are billed by the 55-minute hour at a rate of \$150 per session, and \$220 per 85-minute session. Payment for each session is due at the time of each therapy session. If you carry mental health insurance, arrangements will be made for payment of services from the insurance company and you will be held responsible for deductibles, co-payments, non-covered services, or unpaid balances. You will be billed \$150 for missed sessions unless you cancel at least 48 hours prior to your scheduled session. Exceptions are made if there is an illness or an emergency. In the event that there is inclement weather, I will offer a telehealth session. If you are more than 15 minutes late to an appointment, it will be considered a missed session. There is a \$25 processing fee for checks returned "non-sufficient funds."

If your account has not been paid for more than thirty (30) days and payment arrangements have not been agreed upon, your account will be considered past due and I have the option of using legal means to secure the payment. This may involve using a collection agency or filing a claim in small claims court. In collection situations, I will make all efforts to release the minimum information necessary to proceed with collections or a claim, which will include the client name, dates, times, and the nature of services, and the amount

due. Before I engage a collection agency, I will provide you with written notice of my intent to do so, sent to your last address I have on record, and give you an opportunity to make payment arrangements.

*Health Insurance:* Not all mental health services are covered by health insurance, and it is your responsibility to understand what mental health services your insurance policy covers. I am no longer on any insurance panels, but can provide a superbill to submit to your insurance company to receive out-of-network benefits. I will fill out forms and provide you with whatever reasonable assistance I can to help you receive the benefits to which you are entitled. If you have questions about what your policy covers, you should contact your plan administrator to better understand your coverage. It is often the case that covered mental health services are limited to short term treatments, and it may be necessary to seek approval for therapy after a certain number of sessions. In order for us to set realistic goals for treatment, it is vital that you have a good understanding of your benefits and evaluate the resources that you have available to pay for treatment. In addition, insurance companies may not provide reimbursement for all aspects of the services I provide such as preparing treatment summaries, records, or professional consultations. Due to **Medicaid** laws, Mary Costello Stevens, LLC is prohibited from treating clients who receive **Medicaid** under any circumstance. Please inform us if you receive **Medicaid** and we will provide you with referrals for **Medicaid** providers.

**If, for any reason, your insurance company, HMO, or other third-party payor does not compensate me for the services I provide, you are solely responsible for full payment of my fees. In addition, signing this form gives me permission to communicate with your insurance company, HMO, other third-party payor, collection agency, or anyone connected to your therapy funding source regarding payment. Your insurance company may request information about the services I provide, including but not limited to a diagnosis, description of services or symptoms, treatment plan or summary, and in some cases, your entire client file. Once your insurance company receives such information, I have no control over the security measures the insurance company uses to protect the information or whether the insurance company shares the information. You may request a copy of any report that I submit to your insurance company on your behalf. In these situations, I will try to release the minimum information necessary.**

*Confidentiality:* The information provided by you during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, and psychologists; licensed or certified addiction counselors; and registered psychotherapists, except as provided in section 12-43-218 and except for certain legal exceptions that will be identified by your therapist should any such situation arise during therapy. Information regarding treatment may be shared with a third party only with written consent from the client. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect and elder 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 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 any threats against locations such as churches, schools, theaters, workplaces, etc to law enforcement; and (6) I may be required by Court Order to disclose treatment information.

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 be necessary.

In the case of working with minors, under Colorado law, C.R.S. § 14-10-123.8, parents have a right to access mental health treatment information concerning their child (though privacy will be respected as much as possible, unless the court has restricted access to such information. When treating couples and/or families, confidentiality among family members will be upheld as much as possible, but not a guarantee. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPPA Standards.

*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 to not 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 interest of the family's children.

If you become involved in legal proceedings, I charge \$500 per hour for services related to your legal matter. You will be responsible for paying for any professional time I spend on your legal matter, even if the request comes from another party. Professional time spent on your legal matter includes, but is not limited to: attorney fees that I may incur in preparing for or complying with the requested legal services; testimony related matters such as case research, report writing, travel, depositions, actual testimony, cross examination, and courtroom waiting time.

*Statute of Limitations.* Any person who alleges that a mental health professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. I will maintain records as required by law and as described in the "Record-Keeping" section below.

*Record-Keeping.* I maintain paper records of our work together. I take reasonable precautions to protect the privacy and security of any physical paper records including keeping the records in a locked file cabinet. Records are maintained and will be destroyed in accordance with state and federal laws and regulations. I maintain records of our work together for seven years, or in case of a minor, seven years after client has turned eighteen.

Records are maintained and will be destroyed in accordance with state and federal laws and regulations. Currently, Colorado law requires that I maintain your records for a period of seven (7) years commencing on the date of termination of services or the date of last contact with the client, whichever is later. When the client is a child, the records must be maintained for a period of seven years commencing either upon the last day of treatment or when the child reaches 18 years of age, whichever comes later, but in no event shall records be kept for more than 12 years. After this time, your records will be destroyed. If you would like further information about the maintenance of your records, please ask.

*Emergencies:* In a mental health emergency call Colorado Crisis Services at 844-493-8255 or go to your nearest urgent care or emergency center. Calling Mary Costello Stevens, LLC regarding an urgent matter is available provided you leave a voice mail indicating the emergency with a call back number.

*Interruption of Services – Professional Designee.* In the event that I am disabled, die, or become incapacitated, the following provider will act as my Professional Designee and will have access to my client files. The Professional Designee will contact you to notify you of the event and will assist in continuing your care and treatment with the least amount of disruption possible by providing you with referrals and transfer your client record, if requested, to your new provider. If you are not comfortable with the below listed Professional Designee for any reason, please let me know and we will discuss alternatives.

Name: Nancy Brittian  
Address: 2406 W. 32<sup>nd</sup> Ave, Suite D  
Denver, CO 80211  
Telephone: 720-460-0481  
Credentials: LCSW

*Electronic Communications.* 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 utilize reasonable security measures, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. By initialing below, you consent and authorize Mary Costello Stevens, LPC to communicate Protected Health Information (“PHI”) through the following unsecure transmissions (please initial all of your choices):

\_\_\_\_\_ Cellular/Mobile phone, including text messages and voicemails  
 Cell number: \_\_\_\_\_

\_\_\_\_\_ Unsecured email  
 Client's email address: \_\_\_\_\_  
 Therapist's email address: \_\_\_\_\_

\_\_\_\_\_ Appointment/Scheduling Reminder System (Acuity)

\_\_\_\_\_ Other Media: Please describe: Zoom for online therapy sessions

\_\_\_\_\_ I do not wish to have my protected health information transmitted electronically

*"No Secrets" Policy.* When treating a couple or a family, the couple or family is considered to be the client. If one member of the couple or family discloses information that is directly relevant to the treatment of the couple or family, it may be necessary to share that information with the other members of the couple or family for the sake of facilitating treatment. I will use my best judgement in deciding when or if such disclosures will be made and, whenever possible, I will first give you the opportunity to share the information yourself. In addition, if a request is made for the records of couple or family therapy, records will only be released with the consent of all parties, and any information that is released will be released to both members of the couple or to all adults engaging in family therapy. This "no secrets" policy is intended to allow me to continue to provide therapy to the family or couple by preventing, as much as possible, conflicts of interest that may arise. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist for individual treatment.

*Cancellation, No-Shows, and Termination.* If you cancel your appointment within 24 hours of the scheduled time or fail to show up at the appointment without notice ("no-show"), excluding emergency situations, I have the right to charge you for the full amount of the session. Please be aware that most insurance companies will not provide reimbursement for cancellation fees and you will be personally responsible for the payment of any such fees.

If you choose to discontinue therapy for more than sixty (60) days without communicating with me, your therapy will be considered terminated. If you want to resume therapy after termination, please discuss this with me. The ability to resume treatment will depend on availability and will be at my sole discretion.

*Treatment of Minors.* If you are consenting to the treatment of a minor child, you will be required to provide a copy of the most recent Court Order Custody Agreement and/or Parenting Plan, if applicable, that gives you the authority to consent to the treatment of the child. By signing this form, you agree to keep me informed of any supplemental court orders or other proceedings that impact your parental rights, custody arrangements, or decision-making authority. Failure to produce the Court Order will prohibit me from seeing the minor child. If there is joint medical decision-making authority for your child, I will require both parents to consent to treatment and will not proceed until such consent is obtained.

It is beyond the scope of my practice to provide custody recommendations, and any such request will be denied. The Court can appoint professionals who have the expertise to make such recommendations. By signing below, you agree not to subpoena my records or ask me to testify in court or to provide letters or documentation expressing my opinion about custody or visitation. Despite this, a Court may still require me to testify or to provide treatment information to an evaluator. I will comply with these requests as legally required and you will be required to compensate me for time spent providing these services as indicated in the "Professional Fees" section above.

In the course of treatment with your child, I may involve other family members in your child's treatment. However, please remember that my client is your child, not the other family members of the child. Any meetings with you or other family members will be documented in your child's record. These notes will be available to anyone who has legal access to your child's treatment record.

Therapy is most effective when there is a trusting relationship between the therapist and client. Privacy is important in establishing trust, and as a result, it is often important for child or adolescent clients to have a level of privacy around the therapy. It is my policy to provide parents with general information about their child's treatment, but not to share specific information disclosed during therapy. This includes behaviors that you may not approve of but which do not place your child at imminent risk or danger. If I ever feel that your child is in danger, I will communicate this information to you. By way of example, if your child tells me that s/he has tried alcohol a few times at parties, I will not generally share this with you. If your child shares that s/he has been drinking and driving or riding with a drunk driver, I would share this information with you. If you have questions about the types of information I will share, you can feel free to ask me hypothetical questions about situations that I would or would not disclose to you.

Although you may have the legal right to access any written record I keep, by signing this agreement you are agreeing that your child or adolescent should have privacy around their therapy and you agree not to request access to your child's full record.

I have read the preceding information, it has been explained to me verbally by the therapist, and I understand my rights as a client or as the client's responsible party. I agree to the conditions stated above, including policies regarding fees, insurance, cancellations, confidentiality, crisis coverage, and client rights. I also acknowledge that I have received a copy of this Disclosure Statement.

\_\_\_\_\_  
 Client/Patient Signature      Date  
 (Parent Signature if Client is under age 18)

\_\_\_\_\_  
 Witness                                  Date