Heal Through Play
helping children and families thrive
HealThroughPlay.com | 720.295.6837

3005 47th St, F-1
Boulder, CO 80301

Mandatory Disclosure Form

General Information:

As a counseling client, you are entitled to know your rights:

- You are entitled to receive information about my counseling methods and techniques, the length of counseling, and the cost. Please ask if you have questions. You are also entitled to seek a second opinion at any time.
- You may request information concerning your therapist's training, educational degrees, licenses and credentials.
- You may end counseling at any time, although a closing session is recommended.
- You should know that sexual intimacy between a counselor and client is never appropriate and should be reported to the Grievance Board.
- The practice of counselors is regulated by the Colorado State Department of Regulatory Agencies. Any questions or complaints may be addressed to the Director of Heal Through Play and/or:

  Colorado State Department of Regulatory Agencies
  Mental Health Occupations Grievance Board
  560 Broadway, Suite 1350, Denver, CO 80202
- Registered psychotherapists is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and are not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- Sessions may be recorded for therapist review and consultation with a supervisor.

Confidentiality:

The information you provide during counseling is confidential, except as provided in the Mental Health Statute (C.R.S. 12-43-218) such as:

If your counselor has reasonable cause to suspect that a child or elder has been abused or neglected.

- If you appear to be at serious risk for hurting yourself or another.
- If you are involved in a criminal proceeding (i.e. charged with a crime).
- If you are your representative files a lawsuit or grievance against your counselor.

By signing this form I acknowledge that I have read the above information and understand my rights as a client and that I have asked any questions I have about this form:

_____ _____

Client Signature Date

_____ _____

Counselor's Signature Date

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Statement of Fee Policy

Heal Through Play requests that you read and sign this statement to acknowledge your understanding of our policy. Your signature does not bind you to therapy; it does make you responsible for charges incurred.

Fees are payable to Heal Through Play at the time of service.

The fee for outpatient psychotherapy is offered at: $_____ per hour (50 min.)

Auxiliary services are prorated per 50 minutes. Auxiliary services refer to case summaries, school staffing's, consulting with teachers/schools/occupation therapists, court evaluations, any phone call lasting longer than 15 minutes, court reports, and any other service **requested by the client.**

Emergencies: Clients seen in outpatient psychotherapy are assumed to be responsible for their day to day functioning. With this philosophy in mind, our therapists attempt to operate their practices in a way that is responsible to your needs, encouraging of your autonomy, and respectful to their limits. Therefore, they do not carry a pager and are not ordinarily available for crisis calls that occur outside of scheduled appointments. **If you have a true emergency, call 911 or go to the nearest hospital.** However, exceptions to this policy will be made at the therapist's discretion as appropriate need arises. Our therapists check their voicemail messages regularly during business hours. Please leave your name and phone number. They will return your call when they are available.

Client Payment and Agreement

- ☐ I agree to pay in full at each session.
- ☐ I agree to be responsible for completing, filing and collecting third-party (e.g. insurance) reimbursement. An invoice is completed at the end of each session/services in lieu of the therapist filling out the "provider" section of the claims form. Simply attach this statement to your insurance form.
- ☐ I agree to give 24 hour notice when canceling or changing an appointment to have my fee waived.
- ☐ I agree to make a full payment if I change or cancel an appointment without 24 hours' notice.

_____ _____

Signature of Responsible Party Date

_____ _____

Signature of Responsible Party Date

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Policy Statement

What we do:

- Provide counseling for children, adolescents, couples, and families.
- Suggest books, support groups, classes and information for parents that may help with custody, visitation, and shared parenting.
- For court-ordered clients, we can report the number of sessions attended, session dates, and client's involvement in therapy.
- Report harm to self or others according to Colorado Law.

What we DO NOT DO:

- Legal Mediation
- Get involved in the legal aspects of court cases or testify in court, unless subpoenaed by a judge.
- Make recommendations for parenting time, custody or visitation for children in divorce or separation situations.
- Evaluate a child for possible sexual or physical abuse or neglect.

I understand that a second mental health therapist or special advocate specifically hired as an evaluator can offer recommendations to an attorney or to the court. I agree not to request Heal Through Play or any of its therapists to communicate with an attorney or with any court about what he/she knows about me or my child.

I have read and understand these policies.

_____ _____
Parent's Printed Name Date

_____ _____
Parent's Signed Name Date

_____ _____
Parent's Printed Name Date

_____ _____
Parent's Signed Name Date

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Consent for the Release of Confidential Information

I, _____, authorize information for the purpose of service coordination, collaboration, continuity of care and case management activity to be shared with a Heal Through Play LLC representative and:

(Name of agency/person) _____

(Name of agency/person) _____

(Name of agency/person) _____

Information to be shared *(Circle yes or no)*

YES NO Treatment information to include history, diagnosis, progress in treatment, prognosis

YES NO Treatment approaches/plan/goal and status at discharge

YES NO Treatment summary

YES NO Treatment attendance

YES NO Psychological evaluation and testing summaries

YES NO Other (specify) _____

Regarding myself and/or the following person:

Name of child: _____

I also DO / DO NOT

Authorize the above listed agency/agencies/person(s), to release the information identified above regarding myself and/or the person(s) listed above to Heal Through Play, LLC for the purpose of service coordination, collaboration, continuity of care and case management activity.

I understand that my records and/or those of any individual listed above are protected under federal and state confidentiality regulations. This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. Copies of this form may be used in lieu of the original. I understand and agree that this release form may be sent to the entities identified above.

_____ _____

Client Signature Date

_____ _____

Counselor's Signature Date

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Email Correspondence

By signing below, I give authorization to be contacted via email for the purpose of communication regarding myself or my child, whoever is the client.

I understand that email correspondence is not a confidential or secure form of communication, and I understand that there is a possibility that someone other than the intended receiver may intercept the correspondence.

Email Address: _____

Email Address: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

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Credit Card/Debit Card Pre-Authorization Form for Psychotherapy, Missed Appointments, and Past Due Statements

We require your credit card/debit card information for several reasons:

1. If you would like to pay for your session using a credit card, we can keep your credit card on file to charge at the time of each session. **This is optional.**
2. If you miss an appointment without calling 24 hours in advance, then we charge your card for the missed appointment fee.
3. In the event that you have an outstanding balance, then we will notify you in writing that the card will be charged if you do not make arrangements for partial or full payment.

Please complete the following:

I authorize Heal Through Play LLC to keep my signature on file and to charge my Visa, MasterCard, Discover or American Express account for missed appointments in which I have not called 24 hours in advance to cancel and for any outstanding balances past 2 sessions or 30 days.

Optional:
I authorize Heal Through Play LLC to keep my signature on file and to charge my Visa, MasterCard, American Express, or Discover account for an initial or reoccurring charge of $_____ per visit and/or a one time charge of $_____ for previous services rendered. (**If you choose not to use this option, please put $0.00 for the amount.)**

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. I further authorize Heal Through Play LLC to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge and/or to a collection agency if required to collect payment owed.

_____ _____
Clients Signature Date

_____ _____
Cardholder Name Date

_____
Cardholder Billing Address

_____ _____ _____
Account Number Expiration Date CRV (3-4#s)