Disclosure and Consent to Treat

Gary A Johnson Counseling Inc
Gary A Johnson, MDiv, DMin
CO Licensed Professional Counselor, #796

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Regulation of Counseling

The Colorado Department of Regulatory Agencies, Mental Health has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselor, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. Any concerns or complaints about licensed or unlicensed mental health professionals may be addressed to the State Grievance Board, 1560 Broadway Ave, Suite #1350, Denver, CO, 80202, (303) 894-7800.

Client Rights and Important Information

The Colorado Department of Regulatory Agencies requires that you be provided the following information when seeking counseling services. You are entitled to receive information from your counselor about methods of therapy and the therapeutic techniques used. Please ask for this information if you wish to receive it.

- You are entitled to an estimate of the duration of your therapy to the extent this is known.
- You are entitled to information about my fees and requirements for payment.
- You may seek a second opinion from another mental health professional or terminate therapy at any time.
- Sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the CO Department of Regulatory Agencies, the Division of Registration.

Confidentiality

The confidentiality of your counseling is protected by law. Generally, as a therapist I cannot disclose this information provided by or to the client without written consent. There are several exceptions to confidentiality as follows per C.R.S. 12-43-218:

- I am required to report any suspected incident of child or elder abuse or neglect to law enforcement.
- I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened.
- 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
- I am required to report any suspected threat to national security to federal officials.
- I may be required to disclose treatment information when ordered by a court.
- When providing couples therapy my allegiance is to the couple relationship and I do not "hold secrets" for either partner. Early in couples therapy I typically meet with each partner for an individual session(s) as part of therapy and information disclosed during individual sessions may be brought into the couple's sessions when relevant to their therapy. If an individual chooses to share private information with me vital to the couples therapy I may encourage and guide the disclosure of that information. If the individual refuses this disclosure within the couple's session I may determine that it is necessary to discontinue counseling with the couple.

Fees, Payment and Scheduling

Clients are responsible for payment at the time services are rendered. I prefer payment by personal check. I also accept Visa, MasterCard, and Discovery cards, including HSA/FSA accounts. I process credit cards through Intuit Merchant Services, which Meets all PCIDSS Compliance Standards for protecting billing information. A $35 admin fee is assessed on all checks that are returned for insufficient funds.

My fees are based on fifty (50) minute sessions. My normal per session fee is $170/hr for individual and for couples therapy. Phone consultations are billed at my base rate in 15-minute increments.

Changes or cancellations must be made at least 24 hours in advance of any workday. Changes or cancellations received less than 24 hours in advance may be charged a regular per-session rate. Any missed appointment with no notification received will be charged the regular per-session rate.

Insurance

While many insurance policies provide partial coverage for behavioral health services, I am not a provider with any insurance carrier and do not directly bill through any insurance or medical plan. However, upon request I can provide you with a coded invoice you can use to initiate a possible reimbursement process through your insurance company.

Communication/Availability/Social Media Policy

- I check my voicemail and emails at the end of the workday for messages. I am generally not available for emergency situations after normal business hours. If you need this level of professional care please make me aware of this now and I will give you appropriate referrals.
- The use of email: I use Google Suite for email which uses multiple encryption levels, and data at rest in G Suite services is also encrypted. I use email for scheduling and for the secure transmission of documents such as my Disclosure and Consent form, etc. only. I do not conduct therapeutic interventions via emails.
- I am available to receive texts for scheduling purposes only but not for counseling of any kind. Clients should be aware of the risks to confidentiality with texting.
- In order to ensure client confidentiality, I do not "friend" nor communicate with clients through social media.

Benefits and Risks of Distance Therapy

- Benefits include increased accessibility to therapy, ease and flexibility of scheduling, helping parents who have limits to childcare, reduced client stigma and increased sense of safety, high client satisfaction and outcomes, greater choices in therapists who support client values, beliefs, and culture
- Risks include technology interruptions or failures, potential security risks, reduction of non-verbal cues that can result in misunderstandings or misinterpretation of information, potential boundary violations

Supervision/Consultation

My commitment to the highest quality of care for clients requires that I periodically participate in professional supervision, peer and group consultations. The confidentiality of clients is protected in all of these clinical forums. Should I need to make video or audio recordings of sessions for consultation or training I will secure your written permission prior to recording, such permission you are free to deny.

Client Agreement and Consent to Treatment

I authorize treatment of the person(s) named below and agree to pay all fees for such treatment. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party. By signing this document, I voluntarily authorize and consent to mental health and/or consultation services with Gary A Johnson in accordance with the information contained within.

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Name	Signature	Date
_____	_____ _____	_____
Address	City State	Zip

I have received and read the Notice of Privacy Practices Form (HIPAA) _____ _____

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