Quandary Peak Counseling
1777 S. Bellaire Street, Suite 450
Denver, CO 80222
(720) 675-7918

Disclosure Statement and Consent for Services

Welcome to my practice. The purpose of this form is to let you know important information about my professional services. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. I know it is lengthy, but I believe it is important that you fully understand the therapeutic process.

Therapist

I, Dr. Garry (Trey) Cole, earned my doctorate in Clinical Psychology from the University of Denver, whose program is approved by the American Psychological Association (APA). I completed a doctoral internship in clinical psychology, which was also approved by the APA. I am a Registered Psychotherapist in the state of Colorado (NLC.0106578) and am currently being supervised for licensure as a Psychologist.

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. Any questions or concerns regarding your mental health treatment can be directed to:

The Colorado State Board of Registered Psychotherapists 1560 Broadway, Suite 1350
Denver, Colorado 80202 (303) 894-2291

As to the regulatory requirements applicable to mental health professionals: A Licensed Psychologist holds a doctorate degree in the field of psychology and has satisfied all requirements set forth by the board, including obtaining one year of postdoctoral experience and passing all written examinations. He/she is licensed by the state to practice psychology, which includes the observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles.

Psychological Services

Therapy

Therapy varies based on the individual characteristics and personalities of both the therapist and the client, and I may use a variety of methods to help address the problems you bring forward. Therapy requires active participation on your part, including practicing the things we talk about both during sessions and at home. Therapy can have benefits and risks. Since it often involves talking about unpleasant or difficult aspects of your life, some risks include experiencing feelings like sadness, anger, guilt, or loneliness. However, therapy has also been shown to have significant benefits, including improvements in relationships, resolution of specific problems, and fewer feelings of distress. I do not take on clients I do not think I can help. Therefore, I will enter our

relationship with optimism about our progress. However, there are no guarantees regarding what you might experience as a result of therapy.

The initial phone consultation and the first therapy session are times for both of us to evaluate if this is a “good fit.” If we choose to continue with therapy, I will usually schedule one 50-minute per week appointment at an agreed upon time. Some clients choose to attend therapy more or less frequently, depending on individual needs. If services that are beyond the scope of my competencies are requested, referrals will be made to other professionals or agencies.

Based on what I learn about you, I may recommend a medical exam or the use of medication. If I do this, I will fully discuss my reasons with you, so that you can decide what is best. If you are treated by another professional, I will coordinate my services with them and with your own medical doctor. For cases in which I do not have competency in the area of concern or desired treatment approach, I will provide referrals to other clinicians.

Your Rights
As a client seeking mental health services, you have certain rights. You are entitled to receive information from me about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

The laws and standards of my profession require that I keep treatment records. You are entitled to a copy of these records at any time, or I can prepare a summary for you instead. If you do wish to review your records, I recommend that you do so in my presence so that we can discuss the contents.

Therapeutic Relationship
Our relationship is a professional and therapeutic one. In order to preserve this relationship, it is imperative that I do not have any other kind of relationship with you. Social and/or business relationships undermine the therapeutic relationship. Sexual intimacy is never appropriate in a therapeutic relationship and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder. This contact information is listed on the first page of this document. If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

Confidentiality
Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without 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 and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I have reasonable cause to suspect that a child, an elderly person, or a dependent adult is being abused (or if an adult 70+ is being taking advantage of or manipulated), I must file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another person or persons, including those identifiable with a specific location or entity, I am required to take protective actions. These actions may include notifying the potential victim(s), contacting the police, contacting those responsible for the specific location or entity threatened, or seeking hospitalization for the client. Additionally, under the USA Patriot Act, I am required to report threats to national security. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization or to contact family members or others who can help provide protection.

If such a situation occurs in your treatment, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I always maintain the confidentiality of the client's identity. It is my office policy to destroy clients' records 7 years after the end of our therapy. Until then, I will keep your case records in a safe place. If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

Electronic Communication

Please note that cellular phone and e-mail communications are vulnerable to breeches of confidentiality due to their modes of information transmission. I use email communication only with your permission and only for administrative purposes, unless we have made another agreement. Consequently, email exchanges with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. If you need to discuss a clinical matter, please feel free to call so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context is a much more secure mode of communication. If you do choose to email me, please know a record may be kept as part of your legal medical record. Normal email is not considered a secure form of communication.

________ Your initials here indicate you prefer to use non-encrypted email, with the understanding that it is not a secure form of communication. These emails are retained in the logs of yours and Dr. Cole's internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You give Dr. Garry (Trey) Cole permission to use non-encrypted email to communicate with you about things like changing appointments and billing matters.

Professional Fees

Therapy: Your fee per 50-minute session is $________. This fee should be paid on the day of your session. In addition to weekly appointments, I charge my hourly fee for other professional services you might need, though I will prorate the hourly cost for periods totaling less than one hour. Other services include, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my time. Because of the difficulty of legal involvement, I charge a forensic fee for preparation and attendance at any legal proceeding.

If you think you will have trouble paying on time, please discuss this with me. I will also raise the matter with you so we can come to a solution. If your unpaid balance reaches $300, I will notify you by mail. If it then remains unpaid, I must stop therapy with you. In the very rare instance in which your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

PLEASE NOTE: There is no charge for appointments cancelled more than 48 hours in advance of the scheduled time. Missed appointments or appointments cancelled less than 48 hours ahead of time are charged $75, unless in case of unpredictable emergencies (or because of a situation that would be seen by both of us as an unpredictable emergency). Missed or late-cancelled assessment appointments will be charged a flat rate of $75.

Contacting Me

I am not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail, which I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If I am going to be unavailable for an extended period of time, I will provide you contact information for a colleague if necessary. I am also unable to provide 24-hour care or after-hours emergency services. Therefore, appropriate referrals are given to individuals in need of more intensive treatment. Examples include, but are not limited to, individuals who are experiencing acute suicidal or homicidal thoughts, psychosis, or who require inpatient care. In the event of an emergency, contact your local emergency room or your physician and ask for the psychologist or psychiatrist on call.

It is important for you to determine the level of emergency care you would like to have in a therapist. If the above stipulations do not meet your specific needs, please let me know and I am happy to provide you with the names of therapists or agencies that provide 24-

hour care. If you have any questions or concerns about anything stated above or would like additional information, please feel free to ask. I look forward to working with you.

Your signature below indicates the following:
1. You have read the preceding information, it has been provided verbally, and you understand you have the right not to sign this form.

2. You understand your rights as a client, as outlined above.

3. You understand that any points mentioned above can be discussed at any time during treatment and may be open to change.

4. You understand that after therapy begins, you have the right to withdraw your consent to therapy at any time, for any reason. You agree to make every effort to discuss your concerns about progress before ending therapy.

5. You understand that no specific promises have been made to you about the results of treatment, the effectiveness of the procedures used by Dr. Cole, or the number of sessions necessary for therapy to be effective.

6. You consent to voluntary treatment and agree to abide by the terms of this agreement during our professional relationship.

____
Print Name Client's or Responsible Party's

____
Signature Date

____
Print Name Client's or Responsible Party's

____
Signature Date

I, the therapist, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this brochure. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into treatment with the client, as shown by my signature here.

____

Garry (Trey) Cole, PsyD   Date

Consent to Use and Disclose Health Information

This form is an agreement between you and me, Dr. Garry (Trey) Cole. The words "you" and "your" below can mean you, your child, a relative, or some other person if you have written his or her name here (and have authority to consent to treatment):
____

When I diagnose, treat, test, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

Please note: Even in the case I am legally allowed to share your PHI, I will always do my best to ask you to complete a separate form authorizing its disclosure. If you do not sign this form agreeing to my privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, you can get a copy from my website, www.quandarypeakcounseling.com, or by calling me (the Privacy Officer) at (720) 675-7918. If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to the Privacy Officer. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and cannot change that.

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Signature of Client (or Responsible Party) Date

____

Printed Name of Client (or Responsible Party) Relationship to Client

____

Signature of Garry (Trey) Cole, PsyD

Date of NPP provided to Client or Responsible Party: ______________________

Client Information and Demographics Client

Name: ____

Birthdate: ___________________ Age: __________________

Address: ____

City: __________________ State: ____ Zip: __________

Main phone: __________________________ Email address*: ____________________

* please see my Electronic Communication Policy for information about how I use email in my practice

Describe any considerations you would like me to take in using the above contact number (e.g. leaving a message):

Can I send you mail at the address above (e.g. invoices, letters, etc.)? ❑ Yes ❑ No

Emergency Contact Name: ____

Main phone: _____________________ Relationship to you: ______________________

Can I contact this person in the event of an emergency? ❑ Yes ❑ No

If I need to contact this person, are there any concerns you would like me to be aware of (e.g. confidentiality)? ❑ Yes ❑ No Please specify:

Referred by:____
I often thank my referrals for sending you my way (only professional ones—I would not contact your family or friends). Is this okay with you? ❑ Yes ❑ No