CLIENT – THERAPIST AGREEMENT

Rita K. Berglund, MA, LPC
7600 East Arapahoe Road, Suite 315, Centennial, CO 80112
Phone: 303-523-7111

1. I have a Masters in Transpersonal Psychology from Naropa University in Boulder, Colorado. I am licensed by the State of Colorado as a Licensed Professional Counselor. LPC# 5063

2. The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional and family therapists, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite #1370, Denver, CO 80202, (303) 894-7766.

3. Client Rights and Important Information:

    a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.
    b. You can seek a second opinion from another therapist or terminate therapy at any time
    c. I do <u>not</u> provide emergency services.
    d. In a professional relationship sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.
    e. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed professional counselor. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.
    f. Information disclosed to a licensed professional counselor is privileged communication and cannot be disclosed in any court of competent jurisdiction in the state of Colorado without the consent of the person to whom the testimony sought relates. There are exceptions to the general rule of legal confidentiality. These exceptions include intent to harm others or yourself; abuse or suspected abuse of children, and the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child-custody and divorce court cases. You should be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you should the situations arise during therapy.

4. I charge for psychotherapy services on a negotiated sliding scale. The scale is $125.00 to $150.00 based on the client's annual income. Psychotherapy is provided in a 50 minute hour.

5. In marriage and family counseling, the therapist holds a “no secrets” policy. All members of the couple or family system are treated equally and “secrets” are not kept by the therapist that require differential or discriminatory treatment of family members.

6. I provide only non-emergency psychotherapeutic services scheduled by appointment. If I believe your psychotherapeutic issues are outside my area of expertise or outside my scope of practice, I am legally required to refer, terminate, or consult. If, for any reason you are unable to contact me by telephone, 303-523-7111, and you are having a true emergence, call 911 or check yourself into the nearest hospital emergency room.

7. My supervisor is Duey Freeman, MA, LPC, LLC, License #339. If you have any questions or would like additional information, please feel free to ask during the initial session and any time during the psychotherapy process.

8. CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I understand that I am legally responsible for payment for all psychotherapy services. I also provide release for my therapist to seek consultation with other psychotherapists or professional as the need arises.

_____ _____

Client Signature Date

_____ _____

Therapist Date