

DIANE BAUER^{PLLC}

COMPASSIONATE CONNECTIONS

Diane Bauer, M.S., PACT II
4103 Boardwalk Drive, Suite 202, Fort Collins, CO 80525 (970) 829-8569

Welcome! I am looking forward to working with you and getting to know you throughout the therapeutic process. As an individual(s) receiving services from me, I want you to know about the rights you have as a therapy client:

Qualifications and Regulatory Requirements

My master's degree in Human Development and Family Studies with a specialization in Marriage and Family Therapy was earned at Colorado State University. I received my Bachelor's Degree from the University of Minnesota. Additionally, I have completed all of the requirements to be registered as a psychotherapist in the State of Colorado. I am a member of the American Association for Marriage and Family Therapy (AAMFT) as well as the Colorado Association for Marriage and Family Therapy (COAMT). I provide therapy services for individuals, couples and families throughout Northern Colorado and work closely with my supervisors who are Licensed Marriage and Family Therapists and AAMFT approved supervisors in order to provide my clients with the best services possible. I am certified as a PACT Level II Clinician and as a Gottman Level I Couple's Therapist. Other specialized training includes Discernment Counseling (Minnesota Couples on the Brink Project), Motivational Interviewing, and Mindfulness-Based Stress Reduction. These and other research-based therapeutic modalities are used to support clients through challenges they may be facing and in helping them to reach their therapeutic goals.

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 regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado, 80202, (303)-894-7800. 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 Clinical 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 Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, and is not licensed or certified.

Your Rights as a Therapy Consumer

- a) You have the right to receive information about my methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure for services provided.

- b) You have the right to seek a second opinion from another therapist and may terminate therapy at any point in time without any moral, legal, or financial obligation other than those already accrued. If wanted and/or necessary, I will provide you with the names of other qualified professionals whose services you might prefer.
- c) You have the right to know that, in a professional relationship, sexual intimacy between a therapist and client is never appropriate. If sexual intimacy of any kind occurs, it should be immediately reported to the State Grievance Board.
- d) You have the right not to be discriminated against due to race or ethnicity, sex or gender, age, religion, education, ability, sexual orientation, or socioeconomic status.
- e) You have a right to make a complaint or grievance at any time without retaliation.

Confidentiality

In general, all material discussed during therapy sessions is legally confidential to persons or agencies outside of therapy. Your records are protected and cannot be disclosed without your written consent. *However, there are several instances in which your therapist is legally bound to reveal information obtained during therapy to other persons or agencies without your permission. These situations are:*

- a) If I believe that you are in imminent danger to yourself or others. I am required to report any threat of imminent physical harm by a client to law enforcement as well as to the person(s) being threatened. I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or other, or who is gravely disabled as a result of a mental disorder. 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 regarding my concerns. By signing this Disclosure Statement and agreeing to treatment with me, you consent to this practice, if it should become necessary.*
- b) If I suspect abuse or neglect of any children (past or present) or elders. I am required to report this to law enforcement or child protection (This includes my obligation to report suspected methamphetamine labs when children may be in the vicinity).*
- c) If I suspect you know about or pose a threat to national security or federal officials.*
- d) If I am required by Court Order to disclose treatment information.*

No Secrets Policy

It is important to know that I hold to a 'no secrets' policy in couple/family therapy. In the event that I receive information from one member of a couple/family that is deemed necessary to share with others in the couple/family, I will attempt to have members of a couple/family provide this type of information themselves, with my support. Safety is always my first priority such that secrets that would likely put someone at risk of harm will not be shared.

Other Important Information

- In case you are involved in divorce or custody litigation, my role as your therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this form, you agree not to call upon me as a witness in any such litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and client. Only court appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.
- It is important for you to know that if you are the parent or guardian of a child(ren) and if the child(ren) is/are left unsupervised in general or while we are in session, you are responsible for any accidents or injuries that may occur. Also, if your child and I do an outside session or I drive your child during the session, you are responsible for any accidents or injuries that may happen to your child.

Electronic and Phone Communication

I reserve email correspondence for scheduling purposes only due to confidentiality concerns. By signing this disclosure statement, you are agreeing to only use email correspondence for scheduling purposes and to not send other confidential, identifying, or emergency information via email. Please note that I check messages (both electronic and phone) Monday through Friday during normal business hours and return messages during those times. If you have an emergency, please call 911 or go to your nearest emergency room.

Professional Consultation

The highest standard of practice for mental health professionals is to receive consultation/supervision from their colleagues and/or a supervisor in order to maintain the highest quality of services. I participate in several consultation/supervision groups on a regular basis. The members of these groups include the therapists at "Boardwalk Therapy Center" and several other local therapists. In these groups, we avoid giving identifying information and the therapists are bound by strict confidentiality laws. I also receive individual, direct supervision on a regular basis with Brook Bretthauer. If you are interested, I will provide you a list of names of the other therapists who participate in these groups. If you know any of these therapists personally, professionally, or otherwise, I will not be discussing your case with them in any manner.

Financial Agreement

By signing this form, you indicate that you understand and agree to the following financial payment plan.

- a) My standard charge is **\$90 per 50-minute session** unless we have made arrangements otherwise. A payment of cash, check, or credit card (Mastercard, Visa, American Express, or Discover) is due at the end of each session. If 2 or more sessions are unpaid, we will discuss cessation of any services until payment in full can be made. If you are overdue on your payments, I may assess a fee of 5% on the total balance. I reserve the right to utilize a bill collection agency to collect unpaid fees.
- b) Late cancellations or missed appointments will be billed at my full session rate of \$90, so be sure to cancel within **24 hours of your scheduled appointment time**.
- c) In my practice, I do not directly work with insurance at this time. I am happy to provide you with monthly billing statements which you can submit directly to your insurance company claims process.
- d) A \$20 service charge will be added to all returned checks and must be paid at the next session.

I have read and understand this financial policy and agree to the above stated fees and procedures. I am responsible for the amount of \$_____ per session and agree to pay this amount in a timely manner.

Agreement

I have read all of the information on this statement and understand my rights as a client. I agree to all of the above policies and procedures. I acknowledge that I have received a copy of this Disclosure Statement.

Client Name (please print)

Client Signature (if necessary) Date

Client Name (please print)

Client Signature (if necessary) Date

Parent or Guardian Signature Date

Parent or Guardian Signature Date

Therapist Date