Heather Gowin, MA, LPC

Licensed Professional Counselor 720-837-7962

357 McCaslin Blvd.

Louisville, CO 80027

MANDATORY DISCLOSURE STATEMENT

Name: _____ Date: _____

DOB: _____

In accordance with Colorado State Law, the following information is provided to all persons entering or considering entering psychotherapy.

I am a Licensed Professional Counselor with the Colorado Department of Regulatory Agencies, License # 2513. I received my Master of Arts degree in Clinical Psychology from the University of Colorado in 1998.

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 Board of Licensed Professional Counselor Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303-894-7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters 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 bachelors 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 masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

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Clients Rights and Responsibilities:

A. You are entitled to receive information about me, my methods of therapy, the techniques I use, the anticipated duration of your therapy, and my fee structure. Please ask me if you would like to receive this information.

B. You may seek a second opinion from another psychotherapist, or terminate therapy at any time.

C. 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 board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

D. Generally speaking, the information provided by and to you as the client during therapy sessions is legally confidential and cannot be released without the client' consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statues and the Notice of Privacy Rights you were provided as well as other exceptions in the Colorado and Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

I HAVE READ THE PRECEEDING INFORMATION, IT HAS ALSO BEEN PROVIDED VERBALLY, AND I UNDERSTAND MY RIGHTS AS A CLIENT.

_____ Date: _____

Client/Legal Guardian Signature

_____ Date: _____

Witness Signature

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CONSENT TO TREAT

Name: _____ Date: _____

DOB: _____

I consent to the outpatient psychotherapeutic evaluation and treatment recommended by Heather Gowin, MA, LPC. I am aware that psychotherapy is not an exact science, and that no guarantees have been made regarding the results of treatment.

_____ Date: _____

Client/Legal Guardian Signature

_____ Date: _____

Witness Signature

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FEE AGREEMENT

____ I agree to be responsible for payment at the time of each 50-minute session in the amount of _____.

____ I have _____ insurance and agree to be responsible for my co-payment and/or deductible (if applicable) at the time of each 50-minute session in the amount of _____.

I agree to be responsible for payment in the amount of $40.00 for any missed appointment or appointment cancelled with less than 24 hours notice. I agree that if my check does not clear the bank I will be responsible for an additional fee of $29. I authorize payments of medical benefits to the undersigned physician or supplier for therapeutic services. I accept assignment of benefits to Heather Gowin, MA, LPC.

_____ Date: _____

Client/Legal Guardian Signature

_____ Date: _____

Witness Signature

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STATEMENT OF CLIENT CONFIDENTIALITY

Name: _____ Date: _____

DOB: _____

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent, with the exceptions stated below:

1. In the event of a medical emergency
2. In the event of a threat of harm against myself or others
3. In the event of being gravely disabled
4. In the event of reported child or elder abuse

I understand that I may revoke my consent in writing. Such a revocation will not apply to information previously disclosed, but only to further communication.

_____ Date: _____

Client/Legal Guardian Signature

_____ Date: _____

Witness Signature

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I _____ have received a copy of this office's Notice of Privacy Practices.

_____ Date: _____

Client/Legal Guardian Signature

_____ Date: _____

Witness Signature