Heather L Gowin, MA, LPC
357 McCaslin Blvd.
Louisville, CO 80027
720-837-7962

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 master's degree in their professional and have two years of post-master 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 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 (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2000 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, is not licensed or certified, and no degree, training, or experience is required.

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Client Rights and Responsibilities:

A. You are entitled to receive information about me, my methods of therapy, the techniques I use. Please ask me if you would like to receive this information. The anticipated duration of our therapy, and my fee structure are discussed and provided to you with the Good Faith Estimate included at the end of this paperwork.
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's 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.

____ ____________________

Client/Legal Guardian Signature Date

____ ____________________

Witness Signature Date

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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.

____ ___________________

Client/Legal Guardian Signature Date

____ ___________________

Witness Signature Date

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Fee Agreement

____ I agree to be responsible for payment at the time of each 50-60 minute session in the amount of $150.00.

____ I have __________________ insurance and agree to be responsible for my co-payment, coinsurance, and/or deductible (if applicable) at the time of each 50-60 minute session in the amount of ___________________________.

I agree to be responsible for payment in the amount of $75.00 for any missed appointment or appointment cancelled with less than 24-hour notice. 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.

____ ___________________

Client/Legal Guardian Signature Date

____ ____________________

Witness Signature Date

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Statement of Client Confidentiality

Name: ____________________________________ Date: _____________

DOB: _____________________________________

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

1. 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, because of a mental disorder.
2. I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened.
3. I am required to report any suspected threat to national security to federal officials.
4. I am required to report any suspected incident of child abuse or neglect to authorities.
5. I am required to report any incident of abuse or exploitation of an elder 70 years and older to law enforcement.

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 officer information concerning my concerns. By signing this Statement of Client Confidentiality and agreeing to receive treatment by me, you consent to this practice if it should become necessary.

Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, and in compliance with Colorado law.

Disclosure regarding divorce and custody litigation is as follows: If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the

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court concerning custody or parenting issues. By signing this Client Confidentiality Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney making recommendations concerning custody.

The court can appoint professionals, who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

_______________________________________ _________________

Client/Legal Guardian Signature Date

_______________________________________ _________________

Witness Signature Date

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Acknowledgment of Receipt of Notice of Privacy Rights

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

____________________________________ ______________

Client/Legal Guardian Signature Date

____________________________________ ______________

Witness Signature Date

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Good Faith Estimate

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who is insured but does not plan to use their insurance benefits to pay for health care items and/ or services.

The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your mental health care needs for an item or service. The estimate is based on information known when the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

You are entitled to receive this "Good Faith Estimate" of the charges for psychotherapy services provided to you. While a psychotherapist can't know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider, nor does it include any services rendered to you not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depending on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The one-time fee for an initial diagnostic assessment is **$150 (CPT Code 90791)**. Beyond this, a traditional 50-60 minute psychotherapy session (in-person or via telehealth) fee is **$150 (CPT Code 90837)**. Most clients will attend one psychotherapy visit per week. Still, the frequency of appropriate psychotherapy visits in your case may be more or less than once per week, depending upon your individual needs and preference. When determining your total estimate, it is also important to consider vacations, holidays, emergencies, and sick time. A typical client will schedule up to 46 therapy sessions a year. This means that their out-of-pocket expense will be approximately $6,900 a year. Every client's therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors, including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and your therapist will continually assess the appropriate frequency of therapy. You will work together to determine when you have met your goals and are ready for discharge, and/ or a new "Good Faith Estimate" will be issued should the frequency of sessions needs changed. As related, you may request a new GFE at any time in writing during your treatment.

Good Faith Estimate Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known when the estimate was created. Your provider may recommend additional services not reflected in this Good Faith Estimate.

The Good Faith Estimate is only an estimate—actual items/service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events. You could be charged more if complications or special circumstances occur. Other potential items and/ or services associated with therapy charges may include but are not limited to no-show/ late cancellation fee(s), record request(s), letter writing(s), and in-between session support. Should these items/services be initiated, a new Good Faith Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services. You have a right to initiate a dispute resolution process if the amount charged substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your therapist at any time about questions regarding your treatment plan or the information provided in this Good Faith Estimate.