Disclosure Statement

Lisa Stull MS, LMFT:

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WELCOME:

Welcome to my practice. This psychotherapy disclosure form contains important information about my professional services and business policies. It will answer most of your questions about therapy services at my office. When you sign this form it will represent an agreement between us so please ask for clarification or additional information if needed. I am a Licensed Marriage and Family Therapist with over fifteen years of experience counseling a diverse population in a variety of treatment settings. I earned my Masters of Science in Clinical Psychology from California Polytechnic University and my Bachelors of Science in Social Work from Northern Arizona University. My broad background includes counseling children, adolescents, adults and families with areas of emphasis in mood disorders, anxiety disorders, trauma, conduct disorders, and dysfunctional family systems. In addition, I am a Certified Level II Eye Movement Desensitization and Reprocessing Clinician with considerable experience working with children and adults who have suffered various types of physical and/or sexual abuse, loss and varying degrees of trauma.

THERAPEUTIC EXPERIENCE:

Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital relationship or family relationships. The process of change will, in many ways, be unique to your particular situation. Who you are as a person will help to determine the ways in which you go about changing your life. The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others. As the client, you have the right to ask about a therapist's qualifications, background and orientation. The most important factor in the success of therapy is good communication between therapist and client. In some instances, talking about your difficulties may exacerbate your symptoms, however, over time you should see an improvement. In addition, not all individuals benefit from therapy or working with a particular therapist. If at any time during the therapy you have questions about whether or not treatment is effective, feelings about something I have said or suggested or need clarification of our goals, do not hesitate to bring this up in our session.

REGULATION OF PSYCHOTHERAPISTS:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has the responsibility specifically for licensed professional counselors is the Board of Licensed Professional Counselor Examiners, 1560 Broadway, Suite #1370, Denver, Colorado, 80202, (303) 894-7766.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

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

II. **Financial Agreement**: Each 50-minute session is $125.00 and *will be collected at the start of each session*. If our session runs over one hour you will be billed at a quarterly rate. EMDR is $140.00 per 60-minute session and billed quarterly thereafter. Phone conversations exceeding 5 minutes will be considered phone therapy and will be charged by the quarter hour. I accept cash, check and credit/debit cards. If your personal check is returned for insufficient funds you will be charged the NSF fee and I will no longer be able to accept your personal check in the future. I offer a couple of ways for those who need to pay less to receive a discount. A 10% discount is given for four sessions payed in advance. If these fees pose a financial strain please discuss this with me and I will let you know if I currently have room in my schedule for a sliding scale fee. You are responsible for tracking your session and phone time limits after the initial reminder.

III. You can seek a second opinion from another therapist or terminate therapy at any time.

IV. **Electronic Communication**: Emails, voice-mails and other technological communication may be used during the therapeutic relationship unless you specifically request otherwise. When therapeutic communication occurs by electronic means there are potential risks and benefits, including but not limited to, issues of confidentiality, clinical limitations, transmission difficulties, and ability to respond to emergencies. This therapist is aware of the limitations regarding confidential transmission by Internet or electronic media and will take extra care when transmitting or receiving such information.

V. In a professional relationship (such as ours), 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.

VI. **Confidentiality Statement:** Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (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 initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required to disclose treatment information when ordered by a court.

VII. **When Disclosure May Be Required:** Disclosure may be required pursuant to a legal proceeding by or against you. If you initiate litigation and your mental status becomes an issue, the defendant may have the right to obtain the psychotherapy records and my testimony. In couples and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon.

VIII. **No Show and Cancellation Policy:** By scheduling your session you have exclusively reserved this time for your use. **You will be charged for all cancelled and rescheduled appointments with the exception noted below.** You may email or leave a message on my voicemail 24 hours a day, seven days a week to cancel an appointment. Please see the No-Show/Reminder call form.

IX. **Emergencies**: In the event of an emergency please dial 911 and allow emergency services to assist you. If you are having a crisis that does not require immediate attention please feel free to leave a message on my 24-hour voice mail and I will get back to you as soon as possible.

X. **Insurance:** I do not accept insurance for services rendered. If you would like to submit a bill to your insurance company to see if they will reimburse you, I will be happy to provide you with an insurance form at the end of each month.

XI. **Follow Up:** I hereby give permission for Lisa Stull, MS, LMFT to correspond with me by letter or phone to follow up on my progress for a period of one (1) year during and/or after being discharged from therapy.

STATEMENT OF UNDERSTANDING:

It is agreed that you release me from any responsibility and/or recourse relative to any decisions that you make during or after your therapy sessions or at any time thereafter. You will not receive any advice from me, however, I will assist you with options to make responsible and informed decisions about your life and/or relationships. Your progress, improvement and relief from any distress depend entirely upon your willingness to identify issues you want to work on, acceptance of my help, and the effort you put forth.

I have read the preceding information and understand my rights as a client. I also acknowledge that I have received a copy of this Disclosure Statement and the HIPAA Notice of Privacy Rights.

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Client Signature or Parent/Guardian for Minor *Client Signature* *Date*

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Print Name *Print Name*