INFORMED CONSENT FOR PSYCHOTHERAPY

The purpose of this document is to provide you with information about therapy services at Integrated Counseling and Wellness with your therapist. Please read the following information carefully and if you have any questions, please discuss them with your therapist at any time.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the client, and the particular problems that you bring forward. Psychotherapy is not like a medical doctor visit. Instead, it calls for very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

There are many different methods used as we work toward your hopes and goals for therapy. The techniques used most often include but are not limited to: dialogue (talk therapy), emotional exploration, interpersonal feedback, awareness- building, and physical exercises (i.e., relaxation training or progressive muscle relaxation). Your therapist may recommend that you consult with other health care providers or suggest other approaches as an adjunct to your therapy (i.e., group therapy or psychiatric consultation). You have the right to refuse anything that is suggested without being penalized in any way.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Making changes in your beliefs or behaviors can be difficult and can sometimes be disruptive to the relationships you already have. You may find your relationship with your therapist to be a source of strong feelings. At times you may feel that you are not making enough progress. We urge you to discuss any feelings that may arise during these difficult times.

On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Most people who take these risks find that therapy is helpful, and your therapist will do everything they can to help you minimize risks and maximize positive outcomes. That said, there are no guarantees of what you will experience or the outcome of therapy.

The first few sessions will involve an evaluation of your needs. By the end of these sessions, your therapist will be able to offer some first impressions of what your work will include and a treatment plan to follow, if you decide to continue therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, energy, and money, so you should be very careful about the therapist you select. If you have questions about procedures, please discuss them whenever they arise. If your doubts persist, please reach out to our office manager and they will be happy to help you get connected with another mental health professional for a second opinion.

The duration of therapy is something that is very difficult to predict in advance. Some clients may get the help they need in only a few sessions, while others may choose to continue therapy for several months or years. Please feel free to discuss this with your therapist if you have any questions or concerns. You have the right to ask questions about anything that happens in therapy. Your therapist is always willing to discuss the rationale for therapeutic approaches and to consider alternatives that might work better. You may feel free to ask your therapist to try something that you think will be helpful. You can ask about your

therapist's training for working with your concerns, and you can request that ICW refer you to someone else if you decide that your therapist is not the right therapist for you. You are free to leave therapy at any time.

DISCLOSURE STATEMENT & POLICIES

2. Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old. In accordance with best practices, the Mental Health professional will encourage the participation of client's parents for youth under the age of 15. Additionally, the mental health professional may notify the parent or legal guardian, without the minor's consent, if in their professional opinion the minor is unable to manage their own care or treatment, or if the minor expresses any suicidal ideation.

In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is ICW's policy to seek the consent of both parents/legal guardians, however this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination, and this is the governing policy unless the child's health, safety, and welfare could be at risk. If this is the case, you must inform the ICW so that appropriate action for the protection and welfare of the child may be taken.

3. This disclosure statement contains the policies and procedures of ICW and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

4. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.

5. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Professional Counselor Examiners regulates Licensed Professional Counselors and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through ICW's internal process.

6. Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications). All levels of regulation require passing a jurisprudence take-home examination. All mental health professionals are required to complete continuing education for the duration of their active licenses. Certified Addiction Technicians must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or equivalent, and complete 1,000 hours of supervised experience. Certified Addiction Specialists must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselors must have a clinical master's degree, pass the Master Addiction Counselor Exam, and complete 3,000 of supervised experience. Licensed Social Workers 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 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.

CLIENT RIGHTS AND IMPORTANT INFORMATION

As a client you are entitled to receive information from your therapist about their methods of therapy, the techniques they use, the duration of your therapy, if they can determine it, and their fee structure. Please ask if you would like to receive this information. Please read below for more information on your rights as a client and important information.

1. Fees:

ICW fee structure, services, and fee policy are outlined as follows:

a. Individual Therapy:

Licensed Therapist: $140 per hour.

Pre-licensed Therapist: $125 per hour.

Intern Rate: $75 per hour.

Group therapy: $65 per 90-minute session

Substance Use Evaluations: $250 for two-hour appointment

Miscellaneous fees: Letters/documents requested by client: $25/30 min document writing time.

Professional Consultation: Including but not limited to meetings with parents, individuals, and professionals: $125 per hour with prorated fees available.

When utilizing insurance for your sessions, we will do our best to provide you with an accurate estimate of what your client responsibility could look like for behavioral health services. This information generally will come from your insurance's provider portals, or provider services phone lines, and sometimes is open to representative interpretation or deductible information that is subject to delays in updates. Please note, any communication of patient and/or insurance financial responsibility is not a guarantee of payment until processed by insurance. If you have any questions about your specific coverages, please call your insurance's member services to verify.

b. It is the policy of ICW to collect all fees at the time of service, unless you make arrangements for payment and ICW agrees to such an arrangement. In addition, ICW requests that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that ICW may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that ICW may seek payment for your unpaid bill(s) with the assistance of a collection's agency. Should this occur, ICW will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due

account. ICW will not disclose more information than necessary to collect the past due account. ICW will notify you of the intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

c. Therapy fees and treatment are based on a 45–53-minute clinical hour instead of a 60-minute clock hour so that I may review my notes and assessments on your behalf.

d. Cancellations:

Therapy (Individual, Family, & Couples) sessions: at ICW, a minimum of 48 hours' notice is required for rescheduling or cancellation of a psychotherapy appointment. If you are late for a scheduled session, you may lose that session time, or your appointment may be canceled if there is not enough time remaining for a therapeutic appointment. If you are 15 minutes late or beyond, you are considered a "no show." For clients participating in Group Therapy Services at ICW, the cancellation policy is that clients provide 24 hours' notice before a group session, otherwise, it is considered a late cancel. The same policies written below apply to all group clients, with the only difference being a 24-hour notice instead of 48-hour notice.

Without notification, fees will be charged as follows:

i. Cancellations (without 48 hours' notice) and No-shows (no communication prior to missing appointment): Full clinician fee of $75 for clinical interns, $125 for prelicensed clinicians, $140 for fully licensed clinicians.

ICW provides every client, family or couple, or group member with one complimentary late cancel (i.e., notice provided less than 48 hours before the appointment) every 6 calendar months (twice a year), regardless of the number of appointments during that time. Any late cancellations or no shows thereafter will be charged according to the policy above, with no exceptions. ICW recognizes that this is a strict policy, but it prevents ICW from having to make judgments about what constitutes an "emergency" for different people.

The only exception occurs for weather, as follows: Late cancels or no shows are not charged on days when either Poudre School District or Colorado State University close due to inclement weather.

You may avoid a cancellation or no-show fee if you and your therapist are able to reschedule within the same week, however, it may not always be possible to reschedule based on your therapist's schedule. Your therapist may also offer a phone or video session in place of an in-person appointment, if needed. Please note that many insurance companies will NOT provide payment for missed sessions.

If there are 2 missed appointments/late cancellations in a row, or it is becoming a pattern, ICW reserves the right to discharge the client from services due to discontinuing services.

e. Your therapist is a Medicaid provider. If you have or obtain Medicaid coverage that includes mental health services, your therapist is able to offer mental health services to you should your plan be registered with Rocky Mountain Health Plans, Beacon/Northeast Health Partners, or Co Access. As a client at ICW, it is your duty to disclose, regardless of your age, whether you are a Medicaid beneficiary and therefore subject to Medicaid policies and procedures. If you have Medicaid as secondary coverage to your primary insurance carrier, your therapist will be able to offer mental health services to you.

f. Legal Services incurred on your behalf are charged at a higher rate including but not limited to:

attorney fees your therapist may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $325.00 per hour.

g. As a client at ICW, you have the right to receive a “Good Faith Estimate” in writing explaining how much your psychotherapy services will cost. Under federal law, health care providers, including mental health providers, are required to give patients who do not have insurance or who are not using insurance an estimate of the bill for medical items and services. You may request a Good Faith Estimate in advance of an already scheduled psychotherapy session or at any point during your treatment.

2. Restrictions on Uses:

You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however ICW is not required to agree to a restriction request. Please review ICW’s Notice of Privacy Policies for more information.

3. Second Opinion and Termination:

You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

4. Sexual Intimacy:

In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health

Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Professional Counselor Examiners.

5. Confidentiality:

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if

the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Certified and Licensed Addiction Counselor. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client’s consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

6. Exceptions to Confidentiality:

There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado

statutes, C.R.S. §12-245-220. You should be aware that provisions concerning disclosure of confidential

communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S. § 13-90- 107. There are additional exceptions that your therapist will identify to you as the situations arise during treatment or in your professional relationship. For example, your therapist is required to report child abuse or neglect situations; your therapist is required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if your therapist determines that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, they are required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, your therapist is required to report this to the appropriate authorities. Your therapist may also disclose confidential information in the course of supervision or consultation in accordance with ICW policies and procedures, in the investigation of a complaint or civil suit filed against your therapist, or if your therapist is ordered by a court of competent

jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, your therapist may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, your therapist cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though your therapist may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party.

Peer Consultation

Your therapist will be supervised weekly (at least 4 hour per month) by clinical supervisor(s) disclosed in your individual intake document. While your therapist is working with the practice, they are required to consult with their supervisor(s) on their cases and clients. The above confidentiality statement applies to the case consultation meetings. Additionally, your therapist will engage in group supervision with other clinical professionals at ICW. Your therapist will not reveal identifying information and will discuss and process anything coming up with your case as vaguely as possible, unless intervention is required as mentioned in the exceptions to confidentiality section above. Your therapist may also be asked to film and record their sessions and supervisor(s) may ask to sit on their sessions as well. By signing this section, you understand that you may ask your permission to do so and that you have the right to consent or decline at any time. If you consent, you will be sent a separate form to share your direct consent.

Extreme Risk Protection Orders Policy:

According to C.R.S. § 13-14.5-103 a licensed health care professional or mental health professional (as defined in C.R.S. § 13-14.5-102) may file a petition for a temporary extreme risk protection order. Pursuant to article 14.5, an extreme risk protection order may warrant the surrender of firearm(s) when there is a significant risk of causing personal injury to self or others by having custody or control of a firearm(s). If at any time during the course of

treatment the need to enact this policy arises, as the mental health professional, your therapist shall make reasonable efforts to limit protected health information to the minimum necessary to accomplish the filing of the petition. The decision of a licensed health care professional or mental health professional to disclose protected health information, when made reasonably and in good faith to comply with this article, shall not be the basis for any civil, administrative, or criminal liability with respect to the licensed health care professional or licensed mental health professional.

7. “No Secrets” Policy:

When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e. on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your therapist is required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. Your therapist will use their sole discretion and best

judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your therapist will first give the individual the opportunity to make the disclosure to the other party themselves. This “no secrets” policy is intended to allow your therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the couple, or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

8. “No Secrets” in Custody Circumstances Policy:

When treating a Client who is a Minor under the age of twelve (12) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is ICW policy to communicate with both parents/guardians via email (i.e. all communication will “cc” both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, your therapist reserves the right, in their sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, your therapist will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or regulations regarding the protection of the health, safety, and welfare of the child/ren.

9. Extraordinary Events:

In the case that your therapist becomes disabled, dies, or is away on an extended leave of absence (hereinafter “extraordinary event,”) the following Mental Health Professional Designee will have access to their client files. If your therapist is unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let your therapist know if you are not comfortable with the below listed Mental Health Professional Designee and you and your therapist will discuss possible alternatives at this time.

NAME: Disclosed in individual intake document

ADDRESS: 2627 Redwing Road, Suite 120, Fort Collins, CO 80526

TEL: (970) 818-2355

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible, specifically identifying alternative best fit therapists for you. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

10. Maintenance of Client Records:

As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of Professional Counselor Examiners, ICW will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. If the client is a minor, the record shall be retained for a period of seven years commencing either upon the last day of treatment or when the minor reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years. ICW cannot guarantee a copy of your Client Record will exist after this seven-year period.

11. Electronic Records: (with Electronic Records)

ICW may keep and store client information electronically on ICW's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, ICW may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. ICW may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged. ICW may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. ICW uses a cloud-based service for storing or backing up information. The cloud-based backup system ICW uses is Simple Practice and the email service provider ICW uses is Gmail. ICW may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information ICW has employed the following security measures:

Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.

The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.

The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud- based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures ICW employs, please ask.

12. Availability and Response Policy:

ICW normal business hours are from Monday-Thursday, 8:00am-6:00pm. However, as a therapist, the majority of business hours are devoted to seeing clients in therapy, which means your therapist may not always be available for immediate contact via phone, text, or email. This is especially true for emergencies, as your therapist is not equipped to respond immediately. The best way to contact your therapist is via (phone/email). Every effort will be made to respond to you in a clear and timely manner. Voicemails and texts will be returned within 48 hours excluding Saturdays, Sundays, and holidays. Emails will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. It is ICW policy to return all phone calls, texts, and emails during normal business hours (referenced above). Your therapist may also reserve the right, in their sole discretion, to return communication outside of these hours; but any communication which they initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of their normal business hours.

You as a Client agree and understand the following:

1. I understand that ICW may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with ICW's Consent for Communication of Protected Health Information by Unsecure Transmissions. 2. I understand that if I initiate communication via electronic means that I have not specifically consented to

in ICW's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method. 3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my therapist.

4. I understand that ICW does provide Teletherapy, such as therapy over telephone or video platform. If both therapist and client agree to engage in Teletherapy as a treatment modality, I may be asked to complete an additional consent form, and that I agree to utilize a secure and HIPAA compliant means for communication to ensure confidentiality and the protection of private information.

5. I understand that my therapist does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other

friend/connection/follow requests via any social media. Any such request will be denied in order to maintain professional boundaries. I understand that ICW has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" ICW's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on ICW's page as well. I understand that any comments I post regarding therapeutic work between my therapist, and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and not through social media. 6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

7. I understand my therapist provides non-emergency therapeutic services by scheduled appointment only. If, for any reason, I am unable to contact my therapist by the telephone number provided to me and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. I understand I may also use the National Suicide Prevention Lifeline, 988. If I wish to use the local crisis line, I may contact Summit Stone Health Partners Crisis Line at (970) 494-4200. ICW does not provide after- hours service without an appointment. If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will respond in accordance with their availability and response policy, as referenced in the previous section. 8. If my therapist believes my therapeutic issues are above their level of competence or outside of their scope of practice, my therapist is legally required to refer, terminate, or consult.

9. I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance ICW, HMO, third-party payer, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance ICW, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance ICW may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance ICW receives the information I or

my therapist has no control of the security measures the insurance ICW takes or whether the insurance ICW shares the required information. I understand that I may request from my therapist a copy of any report ICW submits to my insurance ICW on my behalf. Failure to pay will be a cause for termination of therapy services.
Medicaid Providers:
10. Health First Colorado Member Billing Providers agree to accept the Health First Colorado payment as payment in full for benefits. Colorado law (C. R. S. 25.5-4-301 (II)) provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Health First Colorado. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service. This law also prohibits providers from billing Health First Colorado members for the estates of deceased Health First Colorado members for Health First Colorado benefits. As such, Health First Colorado members are not responsible for payment for late cancellations or failure to show for an appointment. 11. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.
12. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement, I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to sign a separate Consent for Third-Party Participation Agreement or may have to sign a separate disclosure statement in order to participate in therapy.
13. I understand that should I choose to discontinue therapy for more than days by thirty (30) not communicating with ICW or my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the thirty (30) day period by discussing my decision to resume therapy services with ICW. Ability to resume therapy after thirty (30) days will depend upon my therapist's availability and will be within their sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least thirty (30) days, unless otherwise agreed to in writing.
14. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.
15. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to their relatives, friends, the relatives of friends, people known socially, or business contacts.
16. I understand that should I cancel within 48 hours of my appointment or fail to show up for my scheduled

appointment without notice ("no-show"), excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.
17. In the event that I should appear for a therapy session under what appears to be the influence of drugs or alcohol, my therapist reserves the right to refuse to honor my appointment and may cancel. My therapist will make an effort to secure safe transportation from the therapy office with my consent. Should I decline the offer of transportation or make my own arrangements to leave the office, my therapist is not liable whatsoever for my choice. My therapist is not responsible whatsoever for any actions I may make or anything that should happen to me upon leaving the therapy office and I understand that I cannot hold my therapist liable for any such incidents. I, my legal heirs, executors, administrators, next of kin, successors, or legal representatives knowingly, voluntarily, and expressly waive, release, discharge hold harmless and promise to indemnify and covenant not to sue your therapist, ICW, or its employees or representatives, from any and all injuries or damages of whatsoever kind and nature that I may sustain as a result. 18. I also affirm, by signing this form, I am at least twelve (12) and consent to treatment and therapy services here at ICW. In the event that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of twelve (12) and for whom I am requesting therapy services here at ICW, I understand it is ICW's policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren's treatment in accordance with DORA policy. If I am the non-custodial parent signing this consent form for my minor child/ren's treatment in accordance with DORA's policy, I understand that my access to my child/ren's treatment and client record may be limited by court order.
19. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with ICW, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. I also understand that it is ICW's policy to request and seek consent from both my minor child/ren's parents, but that such consent does not supersede the Court Order Custody Agreement and/or Parenting Plan. By signing this form, I understand and consent to ICW's "No Secrets" in Custody Circumstances Policy as outlined above. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.
20. I understand that my therapist is an intern who is under the supervision of the supervisor named above, and I agree and give my consent to receiving therapy services from the supervised intern named herein. 21. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that ICW is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my

therapist.

ASSUMPTION OF THE RISK AND WAIVER OF LIABILITY RELATING TO CORONAVIRUS/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited to congregation of groups of people.

Integrated Counseling and Wellness as a facility has put in place preventative measures to reduce the spread of COVID-19; however, any therapist at ICW and Integrated Counseling and Wellness as a facility cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending in-person appointments at Integrated Counseling and Wellness could increase your risk and your child(ren)'s risk of contracting COVID-19. Integrated Counseling and Wellness may adjust risk mitigation strategies depending on current county infection rates.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child(ren) may be exposed to or infected by COVID-19 by attending in-person appointments with my therapist at Integrated Counseling and Wellness and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Integrated Counseling and Wellness may result from the actions, omissions, or negligence of myself and others, including, but not limited to any therapist at ICW and Integrated Counseling and Wellness as a facility, as well as other resident providers, their clients, employees, agents, and representatives, at/in Integrated Counseling and Wellness.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren) (including but not limited to personal injury, illness, permanent disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in-person appointments with any therapist at ICW and Integrated Counseling and Wellness as a facility. On my behalf and/or on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless any therapist at ICW and Integrated Counseling and Wellness as a facility, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of any therapist at ICW and Integrated Counseling and Wellness as a facility, its employees, agents, and representatives, whether a

COVID-19 infection occurs before, during, or after participation in any in-person appointments with any therapist at ICW and Integrated Counseling and Wellness as a facility.

Client

TELEHEALTH CONSENT

The purpose of this document is to obtain consent for Telehealth Services with Integrated Counseling and Wellness and its providers. In order to maintain care under certain circumstances, ICW employees, may offer to conduct individual sessions, group sessions, and assessments via telehealth service. ICW includes this consent as part of the intake paperwork as there may times where telehealth sessions are offered as alternatives. If you do not wish to participate in telehealth services, you are not required to do so.

In Colorado, "telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a client's health care while the client and provider are at two different locations. This form of service can consist of live phone or video conferencing through a personal computer or mobile phone.

You understand that you have the following rights with respect to TMH:

1. To withhold or withdraw consent at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any benefits to which you otherwise would be entitled.

2. To rely on the same laws that protect the confidentiality of your medical information as apply to TMH.

3. To rely on the same Colorado and federal statutes, regulations and other applicable laws that give you the right to access your medical information and copies of medical records in accordance with Colorado law as apply to TMH.

4. To know what cybersecurity mechanisms are in place with respect to the platforms that you and your counselor are using.

5. To know why your counselor is using TMH and what their rationale is for the various treatment modalities that they are using.

6. To receive services from a counselor within their scope of practice and expertise.

7. To receive TMH in a platform that does not cause potential harm to you.

TMH set-up requirements:

Your counselor and you will agree upon a primary TMH platform for services and a back-up platform in case of technology failures (see section below about available platforms).

Sessions will be the same length as your typical face-to-face sessions and/or as agreed upon.

To maintain confidentiality, you agree that you will not share your telehealth appointment link with anyone unauthorized to attend the appointment.

You agree to engage in sessions only from a private location where you will not be overheard or interrupted. This can be a private room, car, outside location, etc. If you are unsure how to have a private space for sessions, please talk with your therapist so ICW can help you access services safely.

Your counselor and you will begin each session by verifying your identity, that you are alone, and at which physical location you are at for your safety. You must inform your counselor of your physical location for each session.

You agree to use your own computer or device, one that is not publicly accessible. You will ensure that

the computer or device that you use has updated operating and anti-virus software.

Your counselor will provide TMH sessions from a secure and private location, private device, and ensure their device is updated to the most current operating and anti-virus software.

If you are the parent/guardian of a child under the age of 12, you must be present (in the same house, in a different room to allow your child privacy) and easily accessible by phone in the case of emergency.

You must provide an emergency contact to your counselor who will only contact this person in the event of an emergency.

Types of TMH platforms available:

Integrated Counseling and Wellness uses a variety of TMH platforms (HIPPA-compliant). You have the right to receive more information about any of the listed below.

Phone call to your number on file (HIPAA-Compliant only when you and your counselor both verify your identities before beginning the call)

Telehealth by Simple Practice (HIPAA-Compliant with a BAA)

Zoom (HIPAA-Compliant with a BAA)

Google Meets (Non-HIPAA- Compliant)

In Case of Technology Failures:

If you get disconnected from an audio/phone TMH session, both you and your counselor agree to try to re-enter the session. If you are unable to re-enter the session your counselor will call you to arrange for sending a link for your backup platform or resume session by phone.

Urgent/Emergent Matters:

TMH is not an “on demand” service, and Integrated Counseling and Wellness is unable to respond to urgent and/or emergent matters outside of your scheduled sessions.

If you are ever experiencing an emergency, including a mental health crisis, please call 911, the CO Crisis Services/Suicide Prevention Life Line at (844) 493-TALK (8255), the National Suicide Prevention Lifeline at 1-800-273-8255, or go to your nearest emergency room.

If your counselor believes that you are experiencing an emergency during session, they will call your emergency contact and may contact law enforcement to assist you.

By signing this agreement form you are acknowledging that you understand and agree to the following:

You must inform your counselor of the location in which you will consistently be during sessions. You must inform your counselor if this location changes.

Risks/Benefits of Telehealth Sessions

Generally speaking, the risks and benefits of telehealth are similar to those of in-person sessions. There are additional risks, however.

First, although your therapist will use secure platforms (e.g., Simple Practice, Zoom, Phone) with industry-standard encryption and security, there is no way to guarantee that this software is completely failure-proof. As with any technology, there is a chance of a security breach that would affect the privacy of personal and/or medical information.

Second, since you will be completing sessions in your own home, your therapist cannot guarantee the same level of privacy that you have when you are in the ICW clinic. This means that you are responsible for making sure that you are in a private area where disruptions (e.g., others coming into the room or hearing what you say in another room) are minimized as much as possible.

Third, in the event of group sessions conducted via video, it is possible that your confidentiality could be breached if others in the group are not in a confidential setting.

In order to reduce risks to confidentiality, we suggest that all video or telephone sessions occur in a private room with no one else present and that you wear headphones to limit the possibility of other people overhearing confidential information. In group video sessions, you have the option to turn off your camera so that others may not see you.

Lastly, in the event of a national emergency/crisis, ICW and the employees may need to conduct sessions from their own home which may impact confidentiality further, but that they will conduct their sessions in a private room with headphones and place a noise machine outside of the room in their home.

TMH should not be viewed as a substitute for face-to-face counseling. It is an alternative form of counseling with certain limitations.

TMH is relatively new, and therefore lacks research indicating that it is an effective means of receiving therapy.

TMH may not be appropriate if you are having a crisis, acute psychosis, or suicidal or homicidal thoughts.

TMH may lack visual and/or audio cues, which may increase the likelihood of your therapist and you misunderstanding one other.

TMH may have disruptions or delays in the services being provided due to quality of the technology used. Your counselor does not have access to technological information.

TMH may not be covered by your current insurance policy.

This Consent Form shall be governed by the laws of the State of Colorado.

By Clicking the Box below (which will insert my signature) I acknowledge that there are programs I will be using that may not be HIPAA-compliant if the HIPAA compliant versions are not available. By signing this form, I am stating that I have read, understood and agree to the terms contained in the Telehealth Consent Form, and confirm my agreement to the following:

That I have read or had this form read and/or had this form explained to me.

That I fully understand its contents including the risks and benefits of the technologies.

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client

HIPAA & PRACTICE POLICIES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health information (PHI) used for the purpose of treatment, payment, and health care operations, HIPAA requires that ICW provide you with a "Notice of Policies and Practices to Protect the Privacy of Your health Information" for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which accompanies these Office Policies, explains HIPAA and its application to your personal health information in greater detail. The law requires that ICW obtains your signature acknowledging that ICW has provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. Your therapist is always willing to discuss any question you have about the procedures at any time.

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of PHI. These rights include requesting that your therapist amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about ICW policies and procedures recorded in your records; and the right to a paper copy of these Office Policies, the accompanying Notice of Privacy Practices, and my privacy policies and procedures.

Notice of Privacy Practices

Integrated Counseling and Wellness
2627 Redwing Rd. Suite 120, Fort Collins, CO 80526
EFFECTIVE DATE OF THIS NOTICE This notice went into effect on 01/01/2022
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
I. MY PLEDGE REGARDING HEALTH INFORMATION:
ICW and your therapist understands that health information about you and your health care is personal. ICW and your therapist are committed to protecting health information about you. Your therapist creates a record of the care and services you receive from them. Your therapist needs this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which your therapist may use and disclose health information about you. This notice also describes your rights to the health information your therapist keeps about you and describes certain obligations your therapist has regarding the use and disclosure of your health information. ICW and your therapist are required by law to:

Make sure that protected health information ("PHI") that identifies you is kept private. Give you this notice of your therapist's legal duties and privacy practices with respect to health information. Follow the terms of the notice that is currently in effect.

ICW can change the terms of this Notice, and such changes will apply to all information ICW has about you. The new Notice will be available upon request, in the ICW office, and on the ICW website. II. HOW ICW MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that ICW and your therapist use and disclose health information. For each category of uses or disclosures this notice will explain what your therapist means and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways your therapist is permitted to use and disclose information will fall within one of the categories. For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. Your therapist may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, your therapist would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, your therapist may disclose health information in response to a court or administrative order. Your therapist may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. Your therapist does keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For your therapist's use in treating you.

b. For your therapist's use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For your therapist's use in defending themselves in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate your therapist's compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapynotes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, your therapist will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, your therapist will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, your therapist can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although your therapist's preference is to obtain an Authorization from you before doing so. 5. For law enforcement purposes, including reporting crimes occurring on my premises. 6. To coroners or medical examiners, when such individuals are performing duties authorized by law. 7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition. 8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President ofthe United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those workingwithin or housed in correctional institutions. 9. For workers' compensation purposes. Although your therapist's preference is to obtain an Authorization from you, your therapist may provide your PHI in order to comply with workers' compensation laws. 10. Appointment reminders and health related benefits or services. your therapist may use and disclose your PHI to contact you to remind you that you have an appointment with them. Your therapist may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that they offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT. 1. Disclosures to family, friends, or others. your therapist may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations. VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask your therapist not to use or disclose certain PHI for treatment, payment, or health care operations purposes. Your therapist is not required to agree to your request, and your therapist may say "no" if they believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a healthcare item or a health care service that you have paid for out-of-pocket in full. 3. The Right to Choose How I Send PHI to You. You have the right to ask your therapist to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and your therapist will agree to all reasonable requests.

4.The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that your therapist has about you. Your therapist will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and your therapist may charge a reasonable, cost-based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which your therapist has disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided your therapist with an Authorization. Your therapist will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list your therapist will

give you will include disclosures made in the last six years unless you request a shorter time. Your therapist will provide the list to you at no charge, but if you make more than one request in the same year, ICW will charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that your therapist correct the existing information or add the missing information. Your therapist may say "no" to your request, but your therapist will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client