**MANDATORY DISCLOSURE STATEMENT**

**BRANNON W. PRUET, MA, LPC, CAC II**
**13710 E. RICE PLACE #150**
**AURORA, CO 80015-1057**
**(303) 949-1155**

1. My degrees are: Master of Arts in Counseling, Denver Seminary, 5/2006 and Bachelor of Science in Pre-Medicine/History, Auburn University, 5/1995.

   I am licensed in the State of Colorado to practice psychotherapy. My designation is as a Licensed Professional Counselor (LPC - #5059) and Certified Addiction Counselor (CAC II-# 7256). (Licensed Clinical Social Workers, Licensed Professional Counselors, Social Workers, and Licensed Marriage and Family Therapists must hold a master's degree in their profession and have two years of post-masters supervision. Certified Addiction Counselors (CAC II) must meet the CAC I requirement, complete additional training above the CAC I, and 2,000 hours of clinically supervised work experience.) I have been a clinician in the mental health field for sixteen years with the majority of my experience being centralized in crisis assessment, case management, group/1:1 psychotherapy, and pastoral care (as an independent, evangelical Christian minister). My therapeutic approach is an eclectic one combining cognitive- behavioral, brief, and experiential modalities.

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

   The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Colorado Division of Behavioral Health, 3824 W. Princeton Circle, Denver, Colorado 80236, (303) 866-7400. Questions or complaints can be directed to the above. For addiction counselor questions or complaints please direct such concerns to the Board of Addiction Counselor Examiners, 1560 Broadway, #1350, Denver, CO 80202, 303-894-7800.

3. Client Rights and Important Information:

   a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.

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

   c. 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, Mental Health Section.

   d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist. If the information is legally

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confidential, the therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). For example, I am required by law to report cases of any child who is physically or sexually abused to the County Child Protection Services. Additionally, if individuals become dangerous to themselves or others, or are incapable of caring for themselves, confidentiality will be broken in order to arrange for appropriate care.

You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. There are exceptions that I will identify to you as the situations arise during therapy.

4. Session Length and Fee Information: Counseling sessions are fifty minutes in length and will start promptly at the top of the hour. My general fee for a session is $80.00. I will implement a sliding fee scale to accommodate clients whenever possible. The fee arrangement will be negotiated during the initial intake session.

5. Emergency Procedures: If you experience a mental health emergency after business hours (8 AM- 5-PM), please call 911 or go immediately to the nearest hospital emergency room. You may try my cell phone, but understand I am not always available afterhours.

6. If you have any questions or would like additional information, please feel free to ask. I have read the preceding information and understand my rights as a client/ patient.

_____ _____

Client/Patient Signature Date

_____ _____

Therapist Date

**NOTE:** In RESIDENTIAL, INSTITUTIONAL, or other settings where psychotherapy may be provided by multiple providers, the primary therapist makes the above disclosure.
The INSTITUTION must also provide a disclosure. (See C.R.S. 12-43-214(3))

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## FIRST APPOINTMENT ORIENTATION

Thank you for choosing the Brief Therapy Institute of Denver, Inc for your behavioral healthcare services. We recognize you have many choices and we appreciate your trust in us.

We appreciate your downloading and completing the paperwork prior to your fist session. Completing the paperwork allows your therapist the opportunity to spend a greater amount of time on clinical rather than administrative issues.

Some things to keep in mind:

- ✓ Remember, you can download and print, review, or ask for a complete set of Brief Therapy Institute of Denver, Inc. Privacy Policies.
- ✓ Your therapist will review and answer any questions about this paperwork or other matters.
- ✓ Please bring your authorization number, if given to you by your insurance company.
- ✓ Please bring your insurance card.
- ✓ We will need information about your copayment and/or deductible. If you do not know this information, please contact your insurance company and ask for an explanation of benefit coverage for mental/behavioral health issues.
- ✓ We will need your primary care physician's telephone number.
- ✓ If you have seen a counselor or psychiatrist within the last two years, we will need a telephone number to contact them.
- ✓ It is very helpful for the therapy process if you bring a list of goals for therapy. This will help you and your therapist make better use of the first session.

## GOALS FOR THERAPY, PLEASE LIST.

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# Brief Therapy Institute of Denver, Inc.

**All Information is kept in strict confidence**

## CLIENT INFORMATION

NAME:_____

ADDRESS:_____

STREET CITY STATE ZIP

BIRTH DATE:_____ AGE:_____ GENDER: ____ MALE ____ FEMALE

SOCIAL SECURITY #:_____

RELATIONSHIP STATUS: ____ MARRIED ____ SEPARATED ____ SINGLE ____ PARTNERED

____ DIVORCED ____ COHAB. ____ CHILD

I AGREE TO PAY MY CO-PAY OF _____ AT THE END OF EACH SESSION

IF I AM SELF PAYING, I WILL PAY _____ AT THE END OF EACH SESSION

WHOM SHOULD WE THANK FOR THE REFERRAL? _____

### CONTACT INFORMATION

HOME/CELL PHONE:_____ BEST TIME TO CALL:_____

Can we leave a message?_____

WORK PHONE:_____ MAY WE CALL YOU IN CONFIDENCE AT WORK:_____

Can we leave a message?_____

PARENT TO CONTACT IF PATIENT IS CHILD: _____

### INSURANCE INFORMATION

NAME OF INSURED (if different than patient) :_____

ADDRESS OF INSURED (if different than patient): _____

GENDER: ____ MALE ____ FEMALE BIRTHDATE:_____ SS#: _____

INSURANCE COMPANY:_____ PHONE: _____

ADDRESS: _____

MEMBER ID# _____ GROUP NUMBER:_____

INSURED'S EMPLOYER:_____ STATUS: EMPLOYED TERMINATED LOA

AUTHORIZATION # _____ INSURANCE TYPE: HMO PPO OTHER DEDUCTIBLE: _____

### WHO WOULD YOU LIKE NOTIFIED IN CASE OF EMERGENCY?

NAME:_____ RELATIONSHIP TO YOU:_____

ADDRESS:_____

HOME/CELL PHONE:_____ WORK PHONE: _____

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# AGREEMENTS AND DISCLOSURES

**(for all participants over 18 years of age)**

**AGREEMENTS**

1. I authorize the Brief Therapy Institute of Denver, Inc. to contact the referral source for treatment, payment, or health care operations, **understanding that personal information will need to be released to my insurance company or the company that manages my benefits**.

   _____ yes _____ no

2. I authorize the Brief Therapy Institute of Denver, Inc. to bill my insurance/managed care company for the psychotherapy. The Brief Therapy Institute of Denver may need to disclose clinical information necessary to process all claims.

   _____ yes _____ no

3. I authorize _____ to make payment directly to
   (insurance/managed care company)
   the Brief Therapy Institute of Denver, Inc. for the benefit specified and otherwise payable to me, but not to exceed the usual and customary charges for the services.

   _____ yes _____ no

4. I authorize the Brief Therapy Institute to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment and educational programs during and after the completion of my treatment to my home mailing address.

   _____ yes _____ no

5. I want my primary care physician to be notified of my treatment at the Brief Therapy Institute of Denver?

   _____ yes _____ no

**DISCLOSURES**

1. I realize that the Brief Therapy Institute of Denver, Inc conducts research and I understand that all research is calculated, reported, and described in a manner that maintains my confidentiality and total anonymity.

   _____ yes _____ no

2. I understand the Brief Therapy Institute of Denver, Inc cannot be held responsible for being unable to access me due to telephone devices that may block their calls, my use of a pager system in which I cannot be directly reached, any form of caller identification**, or any type of device that does not allow my therapist to make direct telephone contact with me.**

   ____ yes ____ no

**FINANCIALS** *(Please review this section with your therapist at the first session)*

1. My usual and customary rate for providing direct face-to-face psychotherapy services is $____ per hour, $___ per 45 minutes.
2. You will be billed **$ for not giving a minimum of 24 hours notification** of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered.
3. You will be billed for non covered and non routine services such as extended telephone consultation, crisis intervention, report writing, extended care coordination with other providers at a rate of $____ per minute. You will be informed of events involving additional billing prior to the event.
4. Any legal reporting, consultation, or coordination will be billed at a rate of $____ per minute.

Additional comments/special conditions:

SIGNATURE:_____ DATE:_____

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# Privacy Notice

To comply with federal health insurance portability and accountability act guidelines the Brief Therapy Institute of Denver, Inc. has implemented the following policy regarding patient privacy and confidentiality. You may request a copy of our complete set of guidelines, you can review the guidelines posted in the waiting room, or you may review and download the policies from our web site. Our office holds patient record information confidential and we will only use your information for the following reasons: **treatment, payment and health care operations**. The following is a partial list of whom your information can be disclosed, if needed, to:

- Primary care physicians
- Psychiatrists
- Medical specialists
- Diagnostic facilities
- Hospitals, including psychiatric
- Labs
- Insurance companies
- Billing and collection services
- School officials: administrators, counselors, teachers

## Disclosing Record Information

Release of information to any other entity not listed above will require a signed authorization from you or your guardian. This request must be dated, show who the information is to be released to or requested from, the specific information to be released or acquired. These authorizations will have an end date. Additional requests beyond the end date will require a new authorization. We will keep a record of all disclosures in your file. This information will be available for you to review.

## You Have a Right to Access Your Records

You can review and obtain copies of your records. Our office requires a written request, and we will make the records available within 10 days of your request.

## Record Storage

The Brief Therapy Institute of Denver, Inc stores paper copies of **administrative** records for the appropriate length of time per clinician regulations. **Clinical records** are stored **electronically** for the appropriate length of time per clinician regulations.

## Miscellaneous

If we need to contact you by telephone and leave a message we will only leave our name and our phone number. We will not leave any information on an answering machine or with anyone other than the patient or guardian unless we have your consent. It will be your responsibility to return the call.

## Acknowledgment

I acknowledge that I have reviewed this privacy notice and that I may request or download the Brief Therapy Institute of Denver's full privacy policy.

_____ _____

Signature Date

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**Medical Information – Please complete for all participants in therapy**

| Name | Last 2 years<br>Major medical events | Current medications<br>Prescribed and over the counter | Dosage | Allergies?<br>To what? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Family Physician:** _____ **Phone:** _____

**Psychiatrist:** _____ **Phone:** _____

**Pediatrician Name:** _____ **Phone:** _____

**Tobacco Use:** **Cigarettes** ____ **Chewing** ____ **Other** ____ **How much** _____

**Who** _____

**Alcohol and Drug Use:**

**Who?** **Type?** **Amount?** **Frequency?**

If you use herbal supplements or vitamins, please list:

**Family history of alcohol/drug use, mental health, physical conditions:**

**Member:** **History:**

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