Andrea Forlina, LCSW, RPT-S, EPT/S

Healing Through Play: Counseling Services for Children, PLLC

1355 S. Colorado Blvd., Ste. C-810
Denver, CO, 80222
720-505-3840 andreaforlina@gmail.com www.healingthroughplay.net

DISCLOSURE STATEMENT

This statement is being provided to you so that you are aware of your rights as a psychotherapy client. Please read this, and discuss any questions or concerns you have before signing it.

CREDENTIALS:

I received my Master of Social Work (MSW) degree from the University of Denver in 1995. I became a Licensed Clinical Social Worker in Colorado in 2003; license number 12. I earned the credential of Registered Play Therapist Supervisor (RPT-S) through The Association of Play Therapy in 2016; Certificate #S1902. I earned the credential of Supervisor in Experiential Play Therapy (EPT/S) through The Center for Experiential Play Therapy in 2017; Certificate #26. I am also Level 1 trained in Internal Family Systems (IFS) therapy as of July, 2020.

CLIENT RIGHTS AND OTHER IMPORTANT INFORMATION:

1) You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy and my fees. Please ask if you would like to receive this information.
2) You can seek a second opinion from another therapist or terminate therapy at any time.
3) 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 board that licenses, registers, or certifies the therapist.
4) The information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, social workers, professional counselors, and psychologists; licensed or certified addiction counselors; and registered psychotherapists, except as provided in § 12-245-220 and except for certain legal exceptions which include:
    a. the requirement to report any known or suspected incident of child abuse and/or neglect to the county department of human services and/or to law enforcement;
    b. the requirement to report any known or suspected abuse or exploitation of an at-risk adult or elder, including imminent risk of such abuse
    c. the requirement to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened, including persons identifiable by their association with a specific location or entity;
    d. the requirement 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;
    e. the requirement to report any suspected threat to national security to federal officials; and
    f. the requirement by court order to disclose treatment information.

    In such situations, I may be required to take protective actions which may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If such a situation arises during our work together, I will make every attempt to discuss it fully with you before taking necessary action. In addition, I may disclose confidential information in the course of consultation with other professionals. I will make every effort to avoid revealing your identity in the course of such consultation, and any professional with whom I consult will be legally bound to keep the information confidential. Signing this document gives me permission to consult as necessary. I may also reveal confidential information in the event of an investigation of a complaint or civil suit filed against me or if I am ordered to do so by a court of law. 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.

5) When I am concerned about a client's safety, I may request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treatment with me, you consent to this practice, if it should become necessary.
6) 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, in compliance with Colorado law and HIPAA Standards.
7) I agree not to record our sessions without your written consent; and you agree not to record a session or a conversation with me without my written consent.
8) I do not provide letters in support of emotional support or service animals as an accommodation for housing or travel, because such letters require a disability determination which is beyond the scope of my practice. I can assist with finding a referral if you are in need of such a document.

THERAPEUTIC ORIENTIATION:

Welcome to my psychotherapy practice. I look forward to working with you. My focus is in helping your child make change in the areas you and your child identify. I am flexible in my approach in response to your direction. I think that change and growth occur within a relationship, and that it is the therapeutic relationship which enables people to find their own ways through anxieties, depression, fears, confusion, abuse, and relationship and life changes. My practice provides children, ages 3 to 11, a space to journey from emotional pain to healing. To do this, I utilize play therapy, which is a developmentally appropriate way for children to process their distress. I specialize in Experiential Play Therapy, which is non-directive and helps the child to regain their dignity and an age appropriate sense of control. I also use Internal Family Systems (IFS) therapy, and finished my Level 1 training in IFS in July, 2020.

BENEFITS AND RISKS OF COUNSELING:

As with any treatment, there are benefits as well as risks. The benefits may include improved personal relationships, clearer personal goals and values, and your child may find greater satisfaction in their life. On the other hand, as individuals progress through counseling they may discuss unpleasant memories or feelings. Most of these risks are expected and making important changes in a person's life may be challenging. Finally, even with both parties making their best efforts, counseling may not work out. I am available to discuss any of your assumptions, problems, or possible negative side effects in our work together, and enter the counseling relationship with optimism about your child's progress. Please be aware that touch can be an important therapeutic tool for children, teenagers, and adults. Examples can be playing little piggies, high fives, and hugs.

DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION:

If you are involved in divorce or custody litigation, please understand that my role as a therapist is <u>not</u> to make recommendations to the court concerning custody or parenting issues. I am not a Child Family Investigator (CFI) or Parental Responsibilities Evaluator (PRE), therefore I cannot make recommendations to the court regarding parenting time, custody or decision making. By signing this Disclosure 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. Despite this, a Court may still require me to testify or to provide treatment information to an evaluator. I will comply with these requests as legally required and you will be required to compensate me for time spent providing these services as indicated in the "Fee Structure" section below.

EXTRAORDINARY EVENTS:

In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event"), the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee, and we will discuss possible alternatives at this time.

NAME: Rita Stevermer
ADDRESS: 1355 S. Colorado Blvd. Ste. C-810, Denver, CO 80222
TEL: 720-504-6704
CREDENTIALS: LPC

FEE STRUCTURE:

Initial Consultation (30 minutes)	No charge
Individual Psychotherapy	$130.00/session
No show and Late Cancellations:	$130.00
Written Reports	$130.00/ hr (1 hour minimum)

Phone calls over 15 minutes will be pro-rated at $130/hr

Therapy fees are based on a 50-55 minute clinical hour rather than a clock hour to allow time for review of notes and record-keeping. If we meet for more than the regularly scheduled hour, I will charge accordingly for the additional time. I also charge this same hourly rate for other professional services, such as report writing, telephone calls, preparation of reports or treatment summaries, meeting with other professionals with your authorization, and time spent performing other services you request of me.

Court Involvement: Due to the preparation time required and the potential for missed income by needing to cancel sessions my fee for any court involvement is $300 per hour beginning at the time I leave my office and ending when I am permitted to leave the courthouse. If I am required to testify in court, your or your minor child's confidentiality cannot be guaranteed. You will be responsible for paying for any professional time I spend on your legal matter, even if the request comes from another party. Professional time spent on your legal matter includes, but is not limited to: attorney fees that I may incur in preparing for or complying with the requested legal services; testimony related matters such as case research, report writing, travel, depositions, actual testimony, cross examination, and courtroom waiting time.

APPOINTMENTS:

All therapy appointments are 50-55 minutes long. Please be aware that this includes therapy time with your child and meeting with you either at the beginning or end of the session. Please provide 24-hour notice if you need to cancel an appointment. Please be aware that you will be charged for appointments that you do not cancel 24 hours prior to the scheduled session. Please be aware that if you are late to an appointment, we may not be able to complete a full scheduled session, because there are often sessions scheduled directly after your appointment. You will be charged for the full session even if you are late to the appointment. If you have insurance or another form of third party paying for appointments, please be aware that they often do not pay for late arrivals or missed sessions. This includes victim compensation benefits.

INSURANCE:

Not all mental health services are covered by health insurance, and it is your responsibility to understand what mental health services your insurance policy covers. I will fill out forms and provide you with whatever reasonable assistance I can to help you receive the benefits to which you are entitled. If you have questions about what your policy covers, you should contact your plan administrator to better understand your coverage. It is often the case that covered mental health services are limited to short term treatments, and it may be necessary to seek approval for therapy after a certain number

of sessions. In order for us to set realistic goals for treatment, it is vital that you have a good understanding of your benefits and evaluate the resources that you have available to pay for treatment.

I am in network with only Cigna insurance company. If you will be using Cigna to pay for therapy, by signing this form, you are giving me permission to contact Cigna and the billing clearinghouse company I use. You understand that I have no control over what happens to your or your child's personal health information once it is with those companies. **If, for any reason, Cigna does not compensate me for the services I provide, you are solely responsible for full payment of my fees. In addition, signing this form gives me permission to communicate with Cigna, any collection agency, or anyone connected to your therapy funding source regarding payment. Cigna may request information about the services I provide, including but not limited to a diagnosis, description of services or symptoms, treatment plan or summary, and in some cases, your child's entire client file. Once Cigna receives such information, I have no control over the security measures the insurance company uses to protect the information or whether the insurance company shares the information. You may request a copy of any report that I submit to Cigna on your behalf. In these situations, I will try to release the minimum information necessary.**

If you will be opting out of using Cigna, you understand that you have accepted full responsibility for payment of charges for all services rendered. You also understand that contractual limits on charges agreed to between myself and Cigna do not apply and that you will be charged my regular self-pay rates. You understand that if you choose to later use your insurance, I am not liable and am not obligated to reimburse previous sessions where you have chosen to opt out of billing Cigna. Your opt in to use Cigna will start from the day you notify me of the change and cannot be back-dated to previous sessions.

If you are covered under another insurance carrier, upon your request I can provide a superbill to you to submit to your insurance company for out of network reimbursement. You are responsible for payment in full to me, if you will be submitting a superbill to insurance. Please contact your insurance company to confirm your OON benefits. This includes reimbursement percentage, whether out of network payments go toward deductible payments, and teletherapy coverage if applicable.

If you are pursuing benefits through Victims Compensation, 18th Judicial District and/or Juvenile Probation, Senate Bill 94, or any other third-party, please be aware that case management services and report-writing are not reimbursed by these entities and will be your responsibility to pay for these services.

I am not a Medicaid provider, and cannot provide services to children who are covered under Medicaid.

TELETHERAPY/SOCIAL MEDIA:

Due to the COVID19 pandemic or when clinically appropriate, I can provide therapy sessions via tele-therapy. I do not accept personal friend requests via social media.

DISCHARGE FROM THERAPY:

If you decide to end therapy without prior notification to me, I will consider your child to not be enrolled in therapy with me after a period of 30 days has passed following your child's last therapy session. If you want your child to resume therapy with me after termination, please discuss this with me. The ability to resume treatment will depend on availability and will be at my sole discretion.

EMERGENCIES and AFTER-HOURS/UNSCHEDULED COUNSELING CONTACTS:

I do not provide after-hours counseling so that I may take the necessary steps to care for myself. I cannot assume responsibility for your or your child's day-to-day functioning, as does an institution, such as a mental health agency, inpatient hospital, or day treatment setting. For this reason, you and your child are assumed to be self-responsible and not in need of day-to-day supervision. I encourage you to discuss any expectations of after-hours or emergency care with me,

so, if necessary, an appropriate referral can be made. If there is an emergency during a therapy session with your child and for some reason you are not available, please provide an emergency contact:

Name:_____
Relationship to client:_____
Address: _____
Phone: _____

In case of a mental health emergency or crisis, you can go to the nearest hospital emergency room, and/or you should call **Colorado Crisis Services** at **1-844-493-8255** or **911**.

MAINTENANCE OF RECORDS:

Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later. When the client is a child, the records must be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

REGULATION OF PSYCHOTHERAPISTS:

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Social Work can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

Levels of regulation of mental health professionals in Colorado include licensing (requires minimum education, experience, and examination qualifications), certification (requires minimum training, experience, and for certain levels, examination qualifications), and registration (does not require minimum education, experience, or training.) All levels of regulation require passing a jurisprudence take-home examination.

- An Unlicensed Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Technician must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or an equivalent exam, and complete 1,000 hours of supervised experience. A Certified Addiction Specialist must have a bachelor's degree in behavioral health, complete additional required training hours, pass the National Addiction Exam, Level II or an equivalent exam and complete 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's or doctorate degree, pass the Master Addiction Counselor Exam or an equivalent exam, and complete 3,000 of supervised experience.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination 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 Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.

- A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

I/We, _____, the client or parent/guardian, understand I/we have the right not to sign this form. I/We, have discussed any concerns with you, the clinician. I/We understand that once counseling begins I/we have the right to withdraw at any time. However, I/we will make every effort to discuss my/our concerns about my/our counseling before terminating counseling services. I/We understand that no specific promises have been made to me/us by this clinician about the results of treatment, the effectiveness of the procedures, or the number of sessions required for counseling to be effective. I/We agree to act accordingly to the points covered in this policy statement and agree to enter into counseling with this clinician as shown by my signature here.

_____ _____
Signature of client (or person acting for the client) Date

_____
Printed name (*Relationship to client: __self __parent/guardian __Other person authorized to act on behalf of the client)*

I, the clinician, have met with this/these client (and his/her parent(s) or guardian(s)) for a suitable period of time and have informed him or her of the issues covered in the policy statement. I have responded to his or her questions and believe this person fully understands the issues and policies discussed in this policy statement.

_____ _____
Signature of Clinician Date