**CAMERON GRIDLEY, PSY.D.**  
Licensed Clinical Psychologist  
  
4900 E. Kentucky Ave., Suite 100  
Denver, CO 80246  
Phone: (303) 720-6177

## DISCLOSURE INFORMATION AND CONTRACT

## FOR PSYCHOLOGICAL SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I leave a message? (Y or N): H\_\_\_ W\_\_\_ C\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: \_\_Single \_\_Married \_\_Partnered \_\_Separated \_\_Divorced \_\_Widowed

Name of Spouse/Partner (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and Ages of Children (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I thank this person for referring you? Y / N

**I. CREDENTIALS**  
My academic preparation for this work began with a B.A. in Psychology from Yale University in 1998.  I continued my education at the California School of Professional Psychology in San Francisco, where I attained my Master of Arts in Clinical Psychology ('04) and my Doctor of Psychology degree ('06).

I am a licensed clinical psychologist in the state of Colorado. My license number is 3296.

**II. CLIENT RIGHTS**

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

As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a masters degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

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

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

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 State Grievance Board.

**III. PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems that the client brings. A number of different approaches may be used. In order to be most successful, you will have to work both during our sessions and away from them.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Psychotherapy often requires recalling unpleasant aspects of your history. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to significant reduction of feelings of distress, and better relationships and resolution of specific problems. But there are no guarantees about what will happen.

My normal practice is that within the first few sessions, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own assessment of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you secure an appropriate consultation with another mental health professional. If psychotherapy is initiated, I will usually schedule one fifty-minute session (one appointment hour of fifty minutes duration) per week at a mutually agreed time, although sometimes sessions will be longer or more frequent. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

**IV. FEES**

My fee is $165 per 50-minute session. Longer sessions are prorated based on that fee. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations which last longer than 10 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service which you request of me. In unusual circumstances, you may become involved in a litigation that may require my participation. Because of the complexity and difficulty of legal involvement, I charge $230 per hour for preparation and attendance at any legal proceeding.

**V. CONTACTING ME**

I am often not immediately available by telephone. While I am generally at work between 8am and 5pm, I do not answer the phone when I am with a client. My telephone is answered by a confidential voicemail system that alerts me to all calls. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact if necessary. If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. Emergency contact should only take place by phone. I am not available by text message or other electronic forms of communication besides email.

**VI. PROFESSIONAL RECORDS**

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records, but if you wish, I can prepare an appropriate summary. Because these are professional records, they can be misinterpreted and/or be upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss what they contain. Clients will be charged an appropriate fee for any preparation time required to comply with an information request.

**VII. CONFIDENTIALITY**

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

There are, however, exceptions to the general rule of legal confidentiality. In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if she/he determines that resolution of the issues before her/him demands it.

There are some situations in which I am legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm her/himself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

These situations have rarely arisen in my practice, and should such a situation occur, I will make every effort to discuss it fully with you before taking action. Additional information about the limits of confidentiality is listed in section 12-43-218 of the Colorado Revised Statutes.

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important we discuss any questions or concerns you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex, and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

**VIII. BILLING AND PAYMENTS**

You will be expected to pay for each psychotherapy session at the time it is held. Payment schedules for other professional services will be agreed to at the time these services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or installment payment plan.

Once a fee has been set, payment is expected at the beginning of each office visit, unless other arrangements are made. If alternate billing arrangements are made, the outstanding balance is due and payable within ten days of the end of the month in which services were rendered.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collection agencies or

small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information I would release about a client's treatment would be the client's name, the type of services provided and the amount due.

Appointments cancelled by you without at least 24 hours notice will be charged at the set hourly fee. No charge will be made for appointments missed due to emergencies. (By their nature, emergencies do not occur frequently; if such cancellations arise frequently in the course of treatment, this would require further discussion between us.)

**IX. INSURANCE REIMBURSEMENT**

If you have a health benefits policy, it will usually provide some coverage for mental health treatment or evaluation. I will provide you with whatever assistance I can in facilitating your receipt of the benefits to which you are entitled, including filling out forms, as appropriate. However, you, and not your insurance company, are responsible for full payment of the fee that we have agreed to. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions, you should call your plan and inquire.

You should be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases they may share your information with a national medical information data bank. If you request it, I will provide you with a copy of any report that I submit.

It is important to remember that you always have the option to pay for my services yourself and avoid the complexities described above.

**X. INDEPENDENT PRACTITIONER**  
I am an independent practitioner, and as such am not legally or professionally affiliated with any other mental health professional in Suite 100 of 4900 E. Kentucky Ave, Denver, CO 80246.  My office suite colleagues and I share office space but do not operate otherwise as a group practice.

**XI. CLIENT'S STATEMENT OF UNDERSTANDING AND AGREEMENT**

Please feel free to talk with me regarding any of the information presented in this form. If you do not have any questions, after having read this form please initial each of its pages and sign below to indicate that you understand the above information and that you agree to abide by the policies indicated, including accepting financial responsibility for the above-named client. If you would like a copy of this form for your records, please let me know and I’ll be happy to provide you with one.  
   
  
  
---------------------------------------------------------------------------------------------------------  
**I HAVE READ THE PRECEDING INFORMATION AND UNDERSTAND MY RIGHTS AS A CLIENT.  I CONSENT TO TREATMENT BY DR. GRIDLEY ACCORDING TO THE TERMS DESCRIBED IN THE DOCUMENT.**  
  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Client(s), Client’s Guardian, or Person Date

Assuming Financial Responsibility                                                 

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Therapist Signature                                              Date