Elizabeth Glover
Registered Psychotherapist
Counselor-in-Training
2625 Redwing Road, Suite 175
Fort Collins, CO 80526
elizabethglovertherapy@gmail.com
(970) 795-2275

Statement of Custody Form

I, _____, hereby state that I have _____

(i.e., joint, sole) custody of the following children:

_____	_____
Name	D.O.B.
_____	_____
Name	D.O.B.
_____	_____
Name	D.O.B.
_____	_____
Name	D.O.B.

Furthermore, I hereby consent to the provision of therapy services provided by Elizabeth Glover, to aid the child or children.

Dated this _____day of _____ 20___

_____ _____

Custodial Parent / Legal Guardian Witness

Notes: 1. Joint custody includes married as well as divorced couples.
2. If joint custody, use 1 form for each parent.
3. If sole custody, only one signature required.

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NOTICE OF PRIVACTY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL [INCLUDING MENTAL HEALTH] INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

During the process of providing services to you, **Elizabeth Glover**, will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

USES AND DISCLOSURES OF PROTECTED INFORMATION

General Uses and Disclosures Not Requiring the Client's Consent. I will use and disclose protected health information in following ways:

Treatment. Treatment refers to the provision, coordination, or management of health care [including mental health care] and related services by one or more health care providers. For example, myself or any staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

Payment. Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. For example, I will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment. If you are covered by Medicaid, information will be provided to the State of Colorado's Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.

Health Care Operations. Health Care Operations refers to activities undertaken by myself that are regular functions of management and administrative activities. For example, I may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning, and accreditation, certification, licensing and credentialing activities.

Contacting the Client. I may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

*Required **by** Law.* I will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when required to report certain communicable diseases and certain injuries; and (f) when a Coroner is investigating the client's death.

Health Oversight Activities. I will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, and regulatory programs or determining compliance with program standards.

Crimes on the premises or observed. Crimes that are observed by myself that are directed toward myself, or occur on the office premises will be reported to law enforcement.

Business Associates. Some of the functions of my business are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health

information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

Research. I may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed.

Involuntary Clients. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

Family Members. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

Emergencies. In life threatening emergencies I will disclose information necessary to avoid serious harm or death.

Client Authorization or Release of Information. Elizabeth Glover may not use or disclose protected health information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

YOUR RIGHTS AS A CLIENT

Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information I have regarding you, in the designated record set. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask me for the appropriate request form.

Amendment of Your Record. You have the right to request that I amend your protected health information. I am not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask me for the appropriate request form.

Accounting of Disclosures. You have the right to receive an accounting of certain disclosures I have made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask me for the appropriate request form.

Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. I do not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask for the appropriate request form.

Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information by alternative means or at alternative locations. For example, if you do not want me to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask for the appropriate request form.

Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

ADDITIONAL INFORMATION

Privacy Laws. It is required by State and Federal law to maintain the privacy of protected health information. In addition, I am required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

Terms of the Notice and Changes to the Notice. I am required to abide by the terms of this Notice, or any amended Notice that may follow. I reserve the right to change the terms of its Notice and to make the new Notice provisions

effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in my service delivery sites and will be available upon request.

Complaints Regarding Privacy Rights. If you believe I have violated your privacy rights, you have the right to complain. To file your complaint, call:

Elizabeth Glover, Registered Psychotherapist, ASU Counselor-in-Training
2625 Redwing Rd.
Suite 175
Fort Collins, CO 80526
(970) 795-2275

You also have the right to communicate with my supervisor by calling or sending your complaint to:

Brook Bretthauer, LMFT, EMDR II
2625 Redwing Rd.
Suite 175
Fort Collins, CO 80526
(970) 658-1276

You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to:

The Office of Civil Rights
U.S. Department of Health and Human Services
1961 Stout Street Room 1426
Denver, CO 80294
Phone: 303-844-2024 TDD: 303-844-3439
It is my policy that there will be no retaliation for your filing of such complaints.

I have read the above **NOTICE OF PRIVACTY RIGHTS** carefully and understand my rights as a client.

_____

Client name (print) Date Signature

Elizabeth Glover
Registered Psychotherapist
Counselor-in-Training
2625 Redwing Road, Suite 175
Fort Collins, CO 80526
(970) 795-2275

Consent for the Release of Confidential Information

I, _____ of _____
(Name) (Address)

authorize Elizabeth Glover Registered Psychotherapist, to release information to and receive information from:

_____
(Name of person(s) or organization(s) to which disclosure is to be made)

for the following information: _____
(Extent or nature of information disclosed)

for the following reason(s): _____
(The purpose or need for disclosure)

I understand that my records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by submitting a written request and that this consent expires automatically as described below.

The date, event, or condition upon which this consent expires is: _____

I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. Furthermore, I certify that I have the legal authority to authorize this release.

_____
Client Name (please print)

_____ _____
Client Signature (if required) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist/Witness Date

Elizabeth Glover Registered Psychotherapist, Counselor-in-Training

2625 Redwing Road, Suite 175 **(970) 795-2275**
Fort Collins, CO 80526

Financial Policy

Fees and Payment Options

My fee per therapeutic hour is $75. Payment is due in full at the time of service. I accept cash, check, or credit. If paying in cash, I am unable to provide change so any balance will be positively credited to your account. If you are overdue on your payments, I will assess a fee of 5% on your total balance. There is a $30 service charge for all returned checks. Checks can be made payable to Brook Bretthauer LMFT, EMDR II.

Please give at least 24 hours notice when cancelling an appointment. Appointments not cancelled 24 hours in advance will be charged to your account.

Fees and Services	Amount
Individual, Couples, Family, and Child Therapy	$75 Cash, Check, or Credit
Late Cancellations/Missed Appointments	$75 Cash, Check, or Credit
Returned Checks	$30 per check
Overdue Payments Fee	5% of total due

Insurance

I do not directly bill insurance, however, I can provide you with an invoice that you can submit to your health insurance plan for reimbursement. Please be advised that since I am not yet licensed most insurance companies will not reimburse, however, this allows you to receive therapy at a reduced rate. Most insurance companies require submission of statements within 90-180 days of treatment to qualify for reimbursement. In addition, I am required to provide a diagnosis on your invoice. If you are concerned about having a mental health diagnosis in your medical record, please notify me and we can discuss your options.

Sliding-Scale Fees

As a Counselor-in-Training I accept sliding-scale fee clients, if you are unable to pay my rate of 75 dollars please discuss this with me and we can consider other options. I ask that all sliding-scale clients are particularly careful to pay their fees in a timely fashion and are sure to regularly attend all of their sessions.

Credit/Debit Authorization:

For my records, I keep a card on file on as a needed basis but you are welcome to submit payment in any method that works best for you, including cash, check, and credit/debit cards. I herby authorize Elizabeth Glover and her supervisor Brook Bretthauer LMFT, EMDR II to keep my signature on file and charge my credit/debit card selected below for the following: All charges incurred at the time of service (therapy sessions, court preparation and attendance, document preparation, etc.), including no shows and sessions cancelled without 24 hours notice.

Mark One: ___ Visa ___ MasterCard ___ American Express ___ Discover ___ Other

Mark One: ___ Credit ___ Debit

Cardholder's Name (as it appears on your card): _____

Card Number: _____/_____/_____/_____/

Expiration Date: _____/_____ CVV (3 digit code on back of card): _____

Zip Code : _____

Please be aware that any account 90 days past due will be turned over to a collection agency. At that time, information including your name, address, telephone, date of birth and other identifying information will be supplied to the collection agency.

I understand this form is valid unless I cancel this authorization through written notice to Elizabeth Glover, Registered Psychotherapist, Counselor-in-Training.

Agreement

I have read and understand this financial policy and agree to the above stated fees and procedures.

Client Name	Client Signature	Date
Parent/Guardian/3rd Party Payer Name	Parent/Guardian/3rd Party Signature (if necessary)	Date
Elizabeth Glover *Registered Psychotherapist, Counselor-in-Training*		
Therapist Name	Therapist Signature	Date

Elizabeth Glover
Registered Psychotherapist
Counselor-in-Training

2625 Redwing Road, Suite 175 **(970) 795-2275**
Fort Collins, CO 80526

Disclosure Statement

My Qualifications and Regulatory Requirements

I completed a Bachelor's Degree from Oklahoma State University in Human Environmental Sciences with an emphasis in Human Development and Family Sciences and Early Childhood Development in 2011. After graduation, I taught for seven years and during this time started my graduate studies in Clinical Mental Health Counseling at Adam's State University in Alamosa, Colorado. I am a Registered Psychotherapist and I am in my last semesters of graduate school and will be working on my licensure soon. I work with adults, couples, families, adolescents, and children.

The state regulatory requirements for mental health professionals provide that 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-doctorial 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 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, and is not licensed or certified.

The Therapeutic Process

Change has many costs and benefits, all of which cannot be foreseen. Some possible benefits that may be gained from participating in therapy include more positive relationships, a greater sense of self, a stronger sense of happiness and empowerment, and for children, improved behavior at home and school. In working to achieve these benefits, however, people may experience significant discomfort. Remembering and working through unpleasant events or attempting to change negative behaviors can bring up feelings of anger, fear, depression, frustration, and confusion. As a result, you or your child may have the experience of things getting worse before they get better. While our goal is to improve the quality of life for you or your child, there can be no guarantee of a "cure" in the practice of psychotherapy.

The Length of Therapy

Generally, therapy sessions are 50 minutes long. In my work with children, I will conduct a 40 minute session with your child followed by a 5-10 minute discussion with you. Typically, I schedule sessions on a weekly basis, but as therapy progresses, it may be helpful to schedule more or less frequently depending upon the needs of you or your child. The length of therapy depends on several factors in your or your child's past and present experiences. Generally, the more distant or severe the issue, the longer the process will take. Your progress will be accelerated with your regular and timely attendance. Most important for each child's progress is the caretaker's support through participation in their child's therapy as well as seeking help and knowledge for themselves.

Office Hours and Emergencies

I am in the office by appointment, generally on Monday and Wednesday evenings, some Fridays, and Saturday and Sunday. I check my phone messages and email throughout the week. I do not provide on-call emergency services. If there is an emergency and you cannot reach me, you may call 911 or go to the nearest emergency room. You may also contact the local suicide hotline at 221-2114 during business hours or 221-5551 after hours. When I am on vacation or out of the office, my voicemail will have the contact information for another therapist who will cover my cases for my current clients who may need to speak with a therapist.

Fees

My standard charge per session is $75 unless we have made arrangements otherwise. **Payment is due in full at the time of service.** I accept cash, checks, and credit cards. **Please refer to the Financial Policy for more details on my fees and billing policies**.

Confidentiality

Under specific Colorado statutes and regulations, all information provided by you during therapy sessions is legally confidential to persons or agencies outside of therapy, and can only be shared with your written permission. However, there are certain exceptions to confidentiality including the following: (1) I am required to report any suspected child abuse or neglect to Child Protection Services and/or Law Enforcement; (2) I am required to report any suspected abuse or neglect of an at-risk adult or elderly person; (3) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (4) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or others (suicidal or homicidal), or who is gravely disabled as a result of a mental disorder; (5) I am required to report any suspected threat to national security to federal officers; and, (6) I may be ordered by a court of law to disclose treatment information. Please note that when I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information regarding my concerns. By signing this Disclosure Statement and agreeing to treatment with me, you consent to this practice, if it should become necessary.

Professional Consultation

The highest standard of practice for mental health professionals is to receive consultation/supervision from their colleagues and/or a supervisor in order to maintain the highest quality of services. I participate in consultation/supervision weekly with my supervisor Brook Bretthauer. I will also consult with a professor and fellow counseling students at Adams State University. In these groups, we avoid giving identifying information and the therapists are bound by strict confidentiality laws. If you are interested, I will provide you a list of names of the therapists who participate in the groups. If you know any of these therapists personally, professionally, or otherwise, please let me know and I will not discuss your case with them in any manner.

Secrets

When working with couples and families, it is my philosophy that honesty between individuals is important, and keeping secrets is typically damaging to relationships. In order to help families and couples address their issues, having the option to discuss information openly is vital. As such, I will use my clinical judgment in regards to sharing information/keeping secrets in couple or family sessions that have been disclosed during individual sessions. If this is a concern for you, you and I will have a conversation about how to best share that information. *Please note that I will never disclose information in situations where your safety may be at risk.*

Client's Rights and Grievance Procedure

As a client in therapy, you have the following rights:

1) You have the right to be treated with dignity and respect.
2) You are entitled to information about any procedures, methods of therapy, techniques, fees and the possible duration of therapy.
3) You have the right to terminate therapy at any time without any moral, legal, or financial obligations other than those you have already accrued.
4) You have the right to receive a second opinion from another therapist or to change therapists at any time. If you wish, I will provide the names of at least three other qualified professionals whose services you may prefer.
5) You have the right to review and/or receive a summary of your records at any time.
6) In a professional relationship, sexual intimacy between a therapist and client is never appropriate. If sexual intimacy of any kind occurs, it should be immediately reported to the State Grievance Board.
7) You have a right to expect confidentiality within the limits described above. If you request it, any part of your records can be released to any person or agency you designate.
8) You have the right not to be discriminated against due to race or ethnicity, sex or gender, age, religion, education, ability, sexual orientation, or socioeconomic status.
9) You have the right to be informed of your rights in a way that you understand.
10) You have a right to make a complaint or grievance at any time without retaliation.

If you have complaints or concerns about the way that you have been treated or the services you have received, you may speak directly with me and/or file a grievance with the State Grievance Board at 1560 Broadway, Suite #1350; Denver, CO, 80202; (303) 894-7766.

Agreement:

I have read and understand this disclosure and agree to the above stated policies and procedures.

_____ _____

Client Name (please print) Date **Client Signature** Date

_____ _____

Parent/Guardian Signature Date **Parent/Guardian Signature (if necessary)** Date

_____

Therapist Signature Date

CLIENT COPY

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4) You have the right to receive a second opinion from another therapist or to change therapists at any time. If you wish, I will provide the names of at least three other qualified professionals whose services you may prefer.
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7) You have a right to expect confidentiality within the limits described above. If you request it, any part of your records can be released to any person or agency you designate.
8) You have the right not to be discriminated against due to race or ethnicity, sex or gender, age, religion, education, ability, sexual orientation, or socioeconomic status.
9) You have the right to be informed of your rights in a way that you understand.
10) You have a right to make a complaint or grievance at any time without retaliation.

If you have complaints or concerns about the way that you have been treated or the services you have received, you may speak directly with me and/or file a grievance with the State Grievance Board at 1560 Broadway, Suite #1350; Denver, CO, 80202; (303) 894-7766.

Agreement:

I have read and understand this disclosure and agree to the above stated policies and procedures.

_____ _____

Client Name (please print) Date **Client Signature** Date

_____ _____

Parent/Guardian Signature Date **Parent/Guardian Signature (if necessary)** Date

_____

Therapist Signature Date

Elizabeth Glover
Registered Psychotherapist
Counselor-in-Training
2625 Redwing Road, Suite 175
Fort Collins, CO 80526
(970) 795-2275

Client Information Form

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask questions if something is not clear. The information provided on this questionnaire is confidential and will not be released without your permission.

Basic Information

Client Name (please include maiden name if applicable) _____

Address _____ City/State_____ Zip_____

Home Phone _____ OK to leave messages? Yes No

Work Phone _____ OK to leave messages? Yes No

Cell/Other # _____ OK to leave messages? Yes No

Date of Birth _____ Age _____ Ethnicity_____

Gender: _____ Relationship Status_____

Employment/Occupation (self or parent(s))_____

Income _____ Per _____ Insurance_____

Religious/Spiritual Affiliation: _____

Emergency Contact Information

*In case of an emergency, please list the name, address, and phone number of **two** people that are **not** in therapy with you that I would be able to contact.*

Contact #1:

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

Contact #2:

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

Please sign below, giving your consent to allow your therapist to contact these individuals in an emergency situation as deemed so by your therapist.

Signature: _____Date: _____

If applicable, please list all family members currently residing in your household:

Name of Family Members	**Age**	**DOB**	**Relationship to Client**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many people live in your home, including yourself? _____

Medical History

Please answer the following questions to the best of your knowledge

Physician _____Approximate Date of Last Visit _____

Current Medications/Dosages _____

Significant Medical Conditions _____

Please list the type and amount of alcohol or drugs used currently: _____

_____

Additionally, please describe any past or current problems with alcohol or drug abuse (including attempts to quit or cut down, past treatment, arrests, DUIs, etc.) _____

_____

Have you/your child previously received any psychiatric, psychological, and/or counseling help? Yes No

If yes, please describe briefly _____

_____

Other Relevant Information

If applicable, what is the name, age, and gender of your current spouse or partner?

Name: _____ Age: _____ Gender: _____

Do you feel safe in your current relationship?

Physically: Yes No

Emotionally: Yes No

Do your arguments escalate out of control? Never Rarely Occasionally Very Often

Please list and describe any significant family events you would like for me to know about (i.e., deaths, moves, divorce, etc.): _____

_____

_____

_____

Briefly describe your reason for seeking help _____

_____

_____

_____

Who suggested you contact me? _____

Please circle any of the following concerns you, your child, or your family may be experiencing:

Nervousness
Shyness
Separation/Divorce
Drug Use
Anger
Sleep
Relaxation
Legal Matters
Energy
Loneliness
Education/School
Behavioral Problems
Temper
Children
Toileting
Depression

Sexual Problems
Alcohol
Self Control
Stress
Headaches
Memory
Insomnia
Feeling Inferior
Nightmares
Appetite/Eating
Parenting
Fears
Suicidal Thoughts
Finances
Unhappiness
Work

Tiredness
Ambition
Decision Making
Concentration
Health Problems
Marriage
Death of Loved One
Marital Problems
Stomach Trouble
Other: _____

Please add any additional information that you feel may be helpful to me:

_____

_____

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Thank you for completing this questionnaire!