Therapeutic Mandatory
Disclosure Statement and Contract

Client Personal Information

Today's Date: _____
Full Legal Name: _____ Other/Preferred Name(s): _____
Current Address: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Work Phone: _____
Fax Number: _____ Email Address: _____
DOB: _____ Age: _____

Mandatory Disclosure Statement and Information

Contact Information

Maggie Elliott, MA
Maggie Elliott Counseling, LLC
2460 W. 26th Ave. Suite C-165
Denver, CO. 80211
720-515-7211
maggie@maggieelliottcounseling.com

Education

- Bachelors Degree Obtained from Cornell College
  - Psychology Major
  - Ethnic Studies Major
- Masters Degree Obtained from University of Northern Colorado
  - Clinical Counseling, emphasis in Couples and Family work
- Certificate Obtained from Denver Family Institute
  - Couples and Family Counseling

National and State Licenses, Certifications, and/or Registrations

- Registered Psychotherapist, LPP. 0001292

Professional Trainings (Core Trainings and Trainings 15 Hours or Greater)

- Trauma Focused Cognitive Behavioral Therapy
  - Received August 2014
- Dialectical Behavior Therapy
  - Received August 2016

Professional Memberships and Affiliations

- American Counseling Association
  - 2010 to Present

Liability Insurance

- Carried through the HPSO (Healthcare Providers Service Organization)

General Areas of Competence

My clinical background includes extensive work with couple and family therapy, creativity and personal growth, persistent mental illness, trauma, childhood mental illness, and sexuality counseling. I also specialize in the following modalities: couple and family therapy, human sexuality, Narrative therapy, Structural therapy.

Regulatory Agency

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 Boards of Registered Psychotherapists, Licensed Professional Counselor Examiners, Licensed Marriage and Family Therapist Examiners, Social Work Examiners, and Psychologist Examiners can be reached at:

State of Colorado Department of Regulatory Agencies; Division of Professions and Occupations
Mental Health Licensing Section • 1560 Broadway, Suite #1350 • Denver CO 80202
303.894.7800 Phone • 303.894.7693 Fax • http://www.colorado.gov/ Web

As to the regulatory requirements applicable to mental health professionals:

- A Registered 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 requirement to obtain a registration from the state.
- A Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours, and 1000 hours of supervised experience. A Certified Addiction Counseling II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. A Certified Addiction Counseling III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours, and 2,000 hours of supervised experience. A Licensed Addiction Counselor (LAC) must have a clinical master's degree and meet the CAC III requirements.
- A Licensed Social Worker (LSW) 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 (LCSW), a Licensed Marriage and Family Therapist (LMFT), and a Licensed Professional Counselor (LPC) must hold a master's degree in their profession and have two years of post-masters supervision.
  A Licensed Psychologist (LP) must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

BASIC PARMETERS AND AGREEMENTS OF COUNSELING

- I understand that the following is an agreement between _____ (Client) and Maggie Elliott (Therapist) concerning therapeutic treatment.
- I understand that the therapist will work with the client to create a treatment plan agreed upon by both parties and will review this plan periodically to ensure objectives and goals are being met.
- I understand that on an ongoing basis the therapist and client agree to provide mutual feedback about the quality of the work provided by each.
- I understand that both parties agree to share information openly and honestly in order to ensure a positive therapeutic relationship.
- I understand that the relationship between therapist and client is strictly professional and any dual relationship, including that of a sexual nature is inappropriate and will not be allowed.
- I understand that both parties agree that if there are any concerns about the quality of service provided, they will discuss these matters in detail with the other party prior to taking any action, unless the problem is so serious as to require immediate reporting elsewhere.
- I understand that therapy is hard work and I agree to put forth effort in order to make and maintain therapeutic progress.

FREQUENCY

- I understand that the therapist and client will work together to agree upon an appropriate therapeutic schedule.
- I understand that initial sessions will follow a 90-minute schedule.
- I understand that each following therapeutic session will follow a 50-minute clinical hour.

CONFIDENTIALITY AND PRIVILEDGED COMMUNICATION

- I understand that except as provided by law, all verbal, audio, video, telephone, fax, electronic, or other communications of the client to the therapist about any clinical information such as client names, identifying information, and/or case histories are deemed privileged communications and thus are strictly confidential, as allowed by law.
- I understand that my therapist may be receiving supervision or supervision as part of the requirements for continuing education and training and consent to verbal, auditory, and/or video sharing of my therapy sessions with my therapist's supervisor and that this information is covered by the same legal protections as what is covered in my own therapy.
- I understand that providing an email address for my supervisor to use when contacting me presumes my understanding that this form of communication cannot be guaranteed to be confidential and I release my supervisor from any unintentional liability that this may incur.
- I understand that providing a cellular number for my supervisor to use when calling me presumes my understanding that this form of communication cannot be guaranteed to be confidential and I release my supervisor from any unintentional liability that this may incur.
- I understand that information may be transferred by email or facsimile if deemed necessary to expedite services when appropriate releases of information have been signed.
- I understand that all written, video, auditory, and electronic communications and records are protected by this policy. These records are maintained in a locked or password protected environment and stored according to the requirements of the Colorado Mental Health Statute.
- I understand that my therapist shares an office and file cabinet with another professional and I understand that this professional is covered by the same legal protections as what is covered in my own therapy.
- I understand that my therapist may share office space on occasion with students of Denver Family Therapy, and I understand that no student will have access to my therapeutic file or confidential information.

FEES AND PAYMENT

- I understand that full payment is due at the conclusion of each therapy session.
- I understand that the fee per session is $_____ per 50-minute session or $_____ per 90-minute session.
- I understand that payment can be made with cash, personal check, Apple Pay, Android Pay, VISA, MasterCard, Discover Card, or American Express Card.

AVAILABILITY AND ANSWERING SERVICE

- I understand that telephone calls and electronic communications can be received at any time via telephone, telephone voice mail, and/or email. It is important to note that when calls ring into voice mail, the messages are picked up regularly and will be returned as soon as possible.
- I understand that if there is a major mental health emergency and the therapist cannot be reached, I am advised to seek help at a mental health center, a local hospital, or by calling 9-1-1.
- I understand that the therapist is not an on-call clinician and therefore may not be available for emergency purposes.

CANCELLATION

- I understand that at least 24 hours advanced notice must be provided if a session needs to be canceled or changed. Because appointment times are reserved specifically for scheduled appointments, all cancellations received with less than 24 hours notice will be billed at the regular fee unless due to a personal or weather emergency.

TERMINATION OF COUNSELING

- I understand that this therapeutic relationship may be terminated at any time, for any reason, by either party provided there is adequate lead-time to insure the protection of clients. If it is decided to terminate therapy, both parties agree to inform one another as far in advance as possible, though a minimum of 24 hours notice is recommended unless there has been a more grievous breach of this contract.
- I understand that with a therapeutic relationship of any length, termination and closure are very important processes and most people find their experience to be incomplete if there has not been an adequate opportunity for ending.

I have read, reviewed, and understand all of the preceding information within this contract and I agree to the aforementioned terms:

Client Name: _____

Client Signature: _____ Date: _____

Therapist Name: _____

Therapist Signature: _____ Date: _____