LeBauer
COUNSELING

Matthew LeBauer, LCSW
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CO License: CSW 1518

Disclosure Statement, Informed Consent, Privacy Policies

Service Provider: Matthew LeBauer – *Licensed Clinical Social Worker* – Colorado License: CSW 1518
Education & Degrees: Master of Social Work, New York University, 2007
Bachelor of Arts, Spanish & Latin American Studies, Duke University, 2002

Department of Regulatory Agencies (DORA):
The practice of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies (DORA). DORA can be found online at www.dora.state.co.us. You can contact DORA with questions or concerns at the following address and phone number: 1560 Broadway, Suite 1350, Denver, CO 80202. Tel: 303.894.7766
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 1,000 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.

Client Rights:
You are entitled to information regarding my fees, methods of treatment, and the likely duration of treatment. You have the right to obtain a second opinion from another therapist, and can terminate treatment at any time. I welcome and encourage any questions or concerns you have.

Confidentiality:
Generally speaking, information disclosed to and by you during treatment is confidential and cannot be released without your written consent. Nor can this information be disclosed in any court of competent jurisdiction in the State of Colorado without your written consent. There are some legal **exceptions** including threats of physical violence to self or others, specific locations or entities, or suspicion of domestic violence, child or elder abuse or neglect. The Colorado Revised Statue 12-43-1218 provides a list of exceptions to confidentiality. Provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S. 13-90-107. Under the Colorado state statutes, the possession of child pornography is considered to be child abuse and I am required to report people who tell me they have possessed child pornography. If a legal exception arises during therapy, if feasible, you will be informed accordingly. To promote treatment progress, psychotherapists regularly participate in professional consultation. Consistent with your rights, these consultations are conducted while protecting confidentiality. By my initials below, I assert that I have been offered information and explanation about HIPAA and my rights regarding my Personal Health Information (PHI) and **have been offered the Notice of Privacy Policies and Practices** and Compliance with HIPAA Regarding Confidentiality by LeBauer Counseling.

Initials: ________

Social Networking & Dual Relationships:
Dual relationships are not allowed. Once we have a therapist-client relationship, we cannot have a social, acquaintance, friendship or business relationship. Sexual intimacy between a client and therapist is never appropriate

and should be reported to the governing board immediately. I do not have relationships with clients through personal social media (e.g. Facebook, Twitter, Instagram) though clients may choose to 'follow' my professional online presence for resources and information.

Initials: ________

Communications:

Communications by phone, text or email and outside of my office will be treated as confidential though their confidentiality cannot be guaranteed. The content of phone calls and emails should not be construed as and is not a substitute for therapy. Communication outside of my office, by phone, email, text or other means should be used for non-therapeutic purposes only (unless otherwise stated below) such as for scheduling. Even in such a case, the confidentiality cannot be guaranteed. You are responsible for information included in communications from you outside my office.

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. The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.
NAME: Jenny Glick
ADDRESS: 323 Detroit Street Denver, Colorado 80206
TEL: (720) 457-3342
CREDENTIALS: Licensed Marriage & Family Therapist (MA, MSC, LMFT)

Initials: ________

Fee Structure & Financial Agreement:

My fee as of February 21, 2017 is **$195 per 50-minute session**. My rate is subject to change – I will give you advanced notice of any changes. My **sessions last 50 minutes**. Sessions that last longer than 50 minutes will be pro-rated: $234 per 60 minutes, $351 for 90 minutes, etc. Payment is expected by the end of each session. I accept **cash, checks, credit cards, and Venmo (@Matt-LeBauer)**. I do not accept insurance of any kind. If you **have, are eligible for or might become eligible for Medicaid**, it is your responsibility to tell me. If you become eligible for Medicaid and do not inform me in writing, **you agree to pay any fees, penalties and reimbursements that may result**. I currently use **Square** and **Ivy Pay** to process credit card payments. Square's user agreement indicates they may store and use some user information such as your name and email address, as do many credit card processing services. Ivy Pay is HIPAA Compliant. **If you prefer to not use a credit card to pay, you may pay with cash or check**.

While occasional phone calls and emails are used for scheduling**, communication lasting more than 10 minutes will be pro-rated at my standard fee**. If you request a referral, summary, report, letter or professional consultation with an outside party (e.g. another therapist), you will be billed for any time necessary to prepare documentation, and to conduct an in-person or phone consultation. Fees for legal consultation/proceedings are different – see below. If I receive a communication from another therapist with a signed release at your request, I will bill for the consultation at our next appointment. I do not communicate with insurance companies or third parties for payments or reimbursements; this includes for medical leave, disability, etc. An additional fee of **$20/hour will be charged for sessions on weekends**.

Checks that are returned will be assessed a **$30.00 returned check fee** to cover bank costs. I do not carry outstanding balances. Delinquent accounts may be sent to collections. Trades, Barters and In-kind payments are not allowed. While the sentiment is appreciated, **favors and gifts are not allowed**.

You, the client, are responsible for updating any pertinent information in your file including contact information and preferences, medications, etc. If you request information from your file, I may provide what is clinically appropriate and therapeutic within my ethical obligation. Fees will be incurred for file review, preparation and any summaries/documentation provided. You the client agree, as represented by your signature below, that **information**

discussed in session or contained in clients' file will not be used or accessed for court or legal proceedings including custody proceedings.

If either of us senses you may find a better fit with another therapist or type of therapy, I will make an informed referral in collaboration with you. If I do not see you for a session for **60 calendar days**, your file will change to a 'closed' status. **You are welcome to return** for treatment any time and your file will be 're-opened.'

Initials: ________

Late Arrivals/Cancelled/Missed Appointments:
An appointment means that specific time is **reserved for you**. Late arrivals cannot be offered extra time, as it is reserved for someone else. If you arrive late, you will be charged the full fee for the shortened session. If you must cancel an appointment, please do so **more than 48 hours in advance**. If an appointment is missed or cancelled with **less than 48 hours' notice**, you will be **billed the full amount** of the session to be paid by the end of the next session. Please notify me as soon as possible if you know you need to re-schedule or cancel. If a request is made to re-schedule, I will do my best to accommodate. If a re-schedule is not made the same week, the cancellation fee will apply, to be paid by the end of the next session. If Denver Public Schools cancels the school day for snow or weather, the fee for late cancellation will be waived.

Initials: ________

Credit Card Information for Missed Appointments:

Circle One: Visa/AmEx/MasterCard/Discover/Other: __________

Name on Card: ____

Card Number: ____

CVV Security Code on Back of Card: __________

Billing Address with Zip Code: ____ Zip Code: _______

Expiration Date: _____________________

I give permission to Matthew LeBauer, LCSW, LLC to charge my credit card the full fee amount for any appointments missed or cancelled with less than 48-hours' notice.

Signature: ____ Date: _________________________

Independent Practitioner:
As an independent practitioner, I am not legally or professionally affiliated with any other mental health professional or business. While my colleagues and I in this office share space, we do not operate as partners, as a group practice nor share treatment responsibilities.

Legal Proceedings & Court Involvement:

If you need support regarding legal issues, I will happily give you referrals. **It is not within my scope of practice or the scope of our agreement to provide evaluations, depositions or expert testimony.** If you are involved in a legal dispute, including divorce/custody, I will avoid any involvement in the legal process. If you need a formal evaluation or expert testimony, I can help you find appropriate providers. If you enter into therapy with me, **you agree not to initiate any subpoena processes directed at me, my business, or my records. You agree not to involve me in any legal proceedings, and agree not to attempt to obtain records of treatment for any such proceedings.**

Additionally, if I am ultimately required to participate in any legal proceedings or consultation (professional consultation and/or expert testimony, either by deposition or at trial), that is related in any way to my providing therapy services to you, a **non-refundable retainer fee of $4,500.00** for services and expenses will be due and payable by you before I commence any work, and a minimum of two weeks prior to any scheduled legal proceeding,

legal consultation with attorney, or court appearance. This retainer fee will be applied to the first 10 hours of work pertaining to your legal proceeding, but will not be applied towards therapy sessions. I may require and you agree to promptly provide an additional retainer after the first 10 hours of work pertaining to your legal proceeding is performed. You agree to pay all fees (at a **rate of $450.00 per hour**) in full incurred for services & activities including, but not limited to legal consultation, professional consultation, supervision, file review, preparation, travel, writing, delay, testimony (at deposition or trial), and follow-up. If an attorney contacts me on your behalf, that will be understood to be a formal request for involvement and fees will be applied and billed. You also agree to pay for any reasonable costs incurred relating to any such required legal proceeding participation. In the event of a settlement or cancellation of the trial/hearing/deposition/consult with less than 72 hours' notice, fees apply for those hours originally set aside for such. By signing below, you agree that should I be required in the future to provide consultation and/or testimony, you will pay for all services provided within 8 days of receipt of my invoice.

If any provision of this Agreement shall be or become invalid under any provision of federal, state or local law, or by a court of competent jurisdiction, such invalidity shall have no effect on the validity or enforceability of the remaining provisions of this Agreement, and they shall continue in full force and effect. This Agreement describes the entire agreement between the parties concerning the subject matter hereof and supersedes all prior or contemporaneous agreements, representations or understandings, written or oral. This Agreement may not be amended, changed or modified except in a writing signed by both parties hereto.

Initials: ________

<u>Duration of Treatment:</u>

The length of your treatment will depend on a number of factors such as the intensity of your distress, the duration of your concerns, and how much time you put into your growth between sessions. I am eager to collaborate with you openly about the duration of treatment. It is an open conversation and the decision is ultimately yours. 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.

<u>Consent for Treatment:</u>
I **voluntarily consent** to mental health treatment with Matthew LeBauer, LCSW, LLC, dba LeBauer Counseling.

As the client, I (or parent/guardian) understand that **I have the right not to sign this form**. My signature below indicates that **I have read this agreement and asked for necessary explanation**. My signature **does not waive any of my rights**. I understand I can discuss any concerns I have about therapy at anytime during treatment.

I understand that I have the right to withdraw my consent to therapy at any time, for any reason and exercise my right to seek a second opinion at any time. I understand that no specific promises have been made to me by this therapist about the results of treatment or the number of sessions necessary for therapy to be effective.

I have read this disclosure in full*, understand and agree to Matthew LeBauer, LCSW's practices and policies and* ***give my informed consent*** *for treatment.*

Initials: ________

____

Printed Name of Client (or Legal Guardian)

____

Signature of Client (or Legal Guardian) Date

Confidentiality & Communication Preferences

Please specify your preferences regarding communications with Matthew LeBauer, LCSW. By providing this information and signing below, you give explicit, written authorization to Matthew LeBauer, LCSW to respond to and initiate communication that may include Protected Health Information ("PHI") with you informed by these preferences.

I, ____, hereby consent and authorize Matthew LeBauer, LCSW to communicate with me and transmit my PHI as necessary through the following non-secure transmissions (please initial your choices):

Contact Preferences				
Please provide the following information:	**Initials**	Priority Order	Ok to call or write?	Ok to send/leave message?
Mailing Address:			□ Send □ Receive	Yes/No
Email:			□ Send □ Receive	Yes/No
Cell Phone:			□ Send □ Receive	Yes/No
Text (SMS):			□ Send □ Receive	Yes/No
Home Phone:			□ Send □ Receive	Yes/No
Work Phone:			□ Send □ Receive	Yes/No

Communications by phone, text or email and outside of my office will be treated as confidential though their confidentiality cannot be guaranteed. The content of phone calls and emails should not be construed as and is not a substitute for therapy. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically. While occasional texts (SMS/MMS), phone calls and emails are used for scheduling or 'checking-in,' **communication lasting more than 10 minutes will be pro-rated at my standard fee**. I consent to Matthew LeBauer, LCSW transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_________ Information related to scheduling/appointments

_________ Information related to billing and payments

_________ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)

_________ Information related to Matthew LeBauer, LCSW's operations

_________ Other Information; Please describe: ______________________________

____

Printed Name of Client (or Legal Guardian)

____

Signature of Client (or Legal Guardian) Date

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720-468-0676
CO License: CSW 1518

SIGNED ACKNOWLEDGMENT OF WAIVER OF RIGHT TO RECEIVE NOTICE OF HIPAA PRIVACY POLICIES

In accordance with 45 CFR 164.520, covered health care providers are required to give their Notice of Privacy Policies to every individual on the first date of services and make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. The Notice of Privacy Policies contains how a client's protected health information may be used and disclosed, and how a client may access that information. A copy of LeBauer Counseling's Notice is provided on its website at: www.lebauercounseling.com and hard copies are also available upon request.

Client's Name: ____

First Date Services were Provided: ______________________________

YOU AS A CLIENT HAVE A RIGHT TO RECEIVE A COPY OF LEBAUER COUNSELING'S NOTICE OF PRIVACY POLICIES IN EITHER A HARD COPY OR ELECTRONIC FORMAT. WAIVING YOUR RIGHT TO RECEIVE A COPY OF LEBAUER COUNSELING'S NOTICE OF PRIVACY POLICIES AT THIS TIME DOES NOT PROHIBIT YOU FROM REQUESTING A COPY IN THE FUTURE.

I, ___________________, Client, hereby waive my right to receive a copy of LeBauer Counseling's Notice of Privacy Policies and acknowledge that LeBauer Counseling offered me a copy of this policy, but I declined to accept it. I understand that waiving this right now does not prohibit me from requesting a paper or an electronic copy in the future.

________________________________ ______________
Client's Signature Date
(Parent/Legal Guardian, if Applicable)

I, ___________________, psychotherapist, affirm that on the first date services were provided to Client, I attempted to provide Client with a hardcopy of LeBauer Counseling's Notice of Privacy Policies and obtain Client's acknowledgment of receipt of the Notice. Client waived his/her right to receive a hard copy of the Notice.

________________________________ ______________
Psychotherapist's Signature Date