

DISCLOSURE STATEMENT

1. INFORMATION

Michael Smith, PhD
2919 17th Avenue, Suite 214
Longmont, CO 80503
(303) 746-7364

2. CREDENTIALS

Licensure: Licensed psychologist in CO and CA

Degrees: BA in Clinical Psychology, MS in Gen-Experimental Psychology and Counseling (double major), MA in Transpersonal Psychology, PhD in Transpersonal/Clinical Psychology

Professional Experience: Self employed as a psychotherapist since 1983, teaching at graduate level for 13 years, regular speaker at conferences, and psychologist for 12 long-term care facilities

Certifications: EMDR at the advanced level, 1991, various certifications in somatic psychotherapy

3. 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 Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social worker, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. Dr. Smith exceeds these requirements.

4. CLIENT RIGHTS AND IMPORTANT INFORMATION

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.

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

c. In a professional relationship (such as ours), a dual relationship such as business and/or sexual intimacy between a therapist and a client is never appropriate. If a dual relationship occurs, it should be reported to the Board that licenses, certifies or registers the therapist.

d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of elder abuse or neglect and child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required 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; (4) I am required to report any suspected threat to national security to federal officials; (5) I am required by HB 14-1271 to report any threats against locations such as churches,

schools, theatres, workplaces, etc. to law enforcement; and (6) I may be required by Court Order to disclose treatment information.

e. 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 concerning my concerns. By signing this Disclosure Statement and agreeing to treatment with me, you consent to this practice, if it should become necessary.

f. 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.

5. DISCLOSURE REGARDING DIVORCE AND CUSTODY LITIGATION

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. 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.

6. TELEPHONE AND EMERGENCY PROCEDURES

If you need to contact me between sessions, please text me at 303-746-7364, or email me at drmichaelsmith@mac.com. You may also leave a voice message at 303-746-7364, but response is much slower. Please use text or email.

I check my text and email messages several times a day and your message will be returned as soon as possible. In case of an emergency, if I am unavailable and you need to talk to someone immediately, please call 911, or go to the emergency room of the nearest hospital.

7. FEES AND INSURANCE

Fees are \$150-\$200 per 55minutes session if paying by cash, check, or credit card. The charge for coaching is \$200 per 55 minutes. Clients are expected to pay the fee at the time of each session, and for co-pays if insurance is involved. Telephone conversations over 5 minutes, site visits, report writing, reading records, travel time, etc. will be charged at the same rate, unless otherwise agreed upon. Upon request, monthly statements will be provided for you and should contain all the necessary information for insurance purposes. Unpaid balances may be sent to collection if necessary.

7. CANCELLATION

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling, or canceling an appointment, unless it is emergent. Unless we reach a different agreement, the full fee may be charged for sessions missed without such notification. Insurance companies do not reimburse for missed sessions.

If you have any questions or would like additional information, please feel free to ask.

Minor children that are to be included in the sessions require parent(s) sign for them. (Please list children in the blanks below)

I have read the preceding information and I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this Disclosure Statement.

CLIENT SIGNATURE PRINT DATE

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MINOR'S SIGNATURE PRINT DATE
(OR GUARDIAN)

MINOR'S SIGNATURE PRINT DATE
(OR GUARDIAN)

THERAPIST SIGNATURE DATE

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***This page is for my records. You keep the first three.**