



**Psychological Services Clinic at UNC**  
*serving the Greeley community for over 50 years*  
**McKee Hall Room 247, Campus Box 131**  
**Greeley, CO 80639 (970) 351-2731**

## CLIENT RIGHTS DISCLOSURE STATEMENT

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Counselor(s): \_\_\_\_\_ Supervisor(s): \_\_\_\_\_  
Counselor's degrees, and/or licenses: \_\_\_\_\_ Supervisor's degrees and/or licenses: \_\_\_\_\_

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**1. 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 boards and can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. The 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 Master's degree in his or her profession and have two years of post-Master's supervision. (A Licensed Psychologist must hold a Doctorate degree in psychology and have one year of post-doctoral supervision.) 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 Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

## 2. CLIENT RIGHTS AND IMPORTANT INFORMATION

a. You are entitled to receive information from me about my methods of therapy or approach to assessment, the duration of your treatment, and our fee structure. Please ask if you would like to receive this information. I am a graduate student and in training in the PSC. I will consult with my supervisors and training group about your counseling/assessment. Sessions will be recorded and observed for my training purposes. These recordings will be erased after supervision and review.

b. You can seek a second opinion or terminate your therapy/assessment at any time.

c. In a professional relationship such as ours, sexual intimacy between a clinician and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies at the address and/or telephone number stated in Section 1, above.

d. Generally speaking, information provided by and to a client in a professional relationship with a clinician is legally confidential, and the information cannot be disclosed without the client's consent. There are several exceptions to confidentiality, some are described in C.R.S. § 12-43-218 and the Notice of Privacy Practices you were provided. Some exceptions to confidentiality include:

- (1) I am required to report any suspected incident of child abuse or neglect to law enforcement. I am not required to report past abuse if the victim is over 18, unless the alleged abuser currently has access to children;

- (2) I am required to report any suspected incident of elder (age 70 or older) abuse or neglect to law enforcement which may include contacting law enforcement to perform a wellness check for the person of concern;
- (3) I am required to report any threat of imminent physical harm by a client to a specific person, including those identifiable by their association with a specific location or entity, to law enforcement, the person(s) threatened, and/or the person(s) responsible for the specific location or entity threatened;
- (4) I am required to initiate a mental health evaluation of a client who is imminently dangerous to him/herself or to others, 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 officials; and
- (6) I may be required by Court Order to disclose treatment information. If legal exceptions to confidentiality arise during our professional relationship, when necessary and appropriate, I will identify them to you.

e. 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.

f. A registered psychotherapist is a psychotherapist listed in the State of Colorado's database and is authorized by law to practice psychotherapy in Colorado but is not licensed and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

**3. DISCLOSURE REGARDING LEGAL ACTIONS:** If you are involved in legal actions (including divorce or custody litigation), or are seeking disability benefits, my role as your clinician does not include making recommendations or offering opinions to the court concerning these matters, unless there has been a written agreement with the PSC that your assessment or counseling services are specifically for that purpose. By signing this Disclosure Statement, you agree not to subpoena me to testify in court or otherwise request 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 or disability benefits. 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.

**4. EMERGENCIES:** Our office hours are Monday-Thursday, 9am-5pm. When we are unavailable, an answering machine will take your call. We will return your call during working hours. **The PSC is unable to respond to crisis situations.** If you are ever in crisis, please call 911 or proceed to the nearest emergency room. We are also closed during university holidays and breaks and in cases where the university closes due to inclement weather. If you or I believe that you would be better served elsewhere due to such limitations, we will try to help you find a more appropriate setting for your counseling.

**5. FEE AND PAYMENT POLICY:** The fee for most counseling services is \$60.00 per semester and \$10-\$60 per session when seeing advanced students. There is no charge for the first session. In most cases, payment is due at the second session. Assessment services and group therapy fees are different. I will discuss your fee with you and record any adjustments below. We accept cash or credit/debit card payment for services. Your fee is \_\_\_\_\_. Parking passes may be purchased for \$1.00/hour at the parking kiosk.

**6. CANCELLATION POLICY:** Clients are responsible for notifying us if they cancel or re-schedule an appointment. Please call (970) 351-2731 at least 24 hours in advance and ask to leave me a message. Repeated missed appointments will result in termination of services here and referral elsewhere.

**7. PERSONAL INFORMATION AND CLINIC FILES:** Information from your file may be shared with PSC staff for administrative purposes such as scheduling and quality assurance.

I have read the preceding information. I understand my rights as a client/patient. I also acknowledge that I have received a copy of this Disclosure Statement and have reviewed the Notice of Privacy Practices.

\_\_\_\_\_  
Client Signature/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor(s)

\_\_\_\_\_  
Date

### **Consent to use your Records for Research and Quality Assurance**

Since we are a university training clinic, we regularly conduct research to monitor the quality of our services and to inform university and community officials about our outcomes. By signing below, de-identified information from your file may be used to describe referrals, treatments results, and trends in client outcomes. Examples of how this information may be used include in annual reports to university administrators regarding how many clients we've served within a specific period of time and a breakdown of those served by demographic variables. We may also review your file to determine how client self-reported levels of distress are related to various demographic, therapist, and treatment variables. This information will never refer to a specific person in an identifiable way.

Your participation is voluntary. You may decide not to let your information be used in this way and once given, your consent to participate can be withdrawn at any time. Refusing to sign or withdrawing your consent will in no way impact the services you are about to receive in the Psychological Services Clinic at UNC. Having read the above and having had an opportunity to ask any questions, please sign below if you are agreeing to let information from your file be used for these purposes. If you have any questions or concerns about research participation at UNC, please contact, Sherry May, IRB Administrator, Office of Sponsored Programs, 25 Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

\_\_\_\_\_  
Client Signature/Legal Representative

\_\_\_\_\_  
Date