Creative Pathways Counseling & Consulting LLC
CLIENT INFORMATION & DISCLOSURE STATEMENT

Date _____ Client Name _____ D.O.B _____

Address_____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell #_____

Employer/School _____ Parent/Guardian _____

Email Address _____ Marital Status _____Yrs_____ Gender _____

In case of an emergency, whom may we contact? _____

Have you had previous Therapy? ___ Yes ___No If yes, with whom? _____

Goal for Therapy _____

Physical health Issues? _____ Medications? _____

Are you currently experiencing anxiety, panic or have any phobias? __Y __N Medications? _____

If Yes, when did you begin experiencing this? _____

Fees:50 minutes (Individual, Couples, Family and Phone) $75.00. Group; $25.00/session. I accept Debit/Credit Cards and Cash only. No personal checks. Insurance: I am not on any Insurance Panels. However, if you have out-of-network benefits for therapy, I will provide you a detailed statement showing the amount you paid for your session. **Cancellation:** If you miss an appointment without a 24-hour notification, expect to pay the full rate for a cancellation fee.

Confidentiality: All information between you and therapist is legally confidential and privileged. There are exceptions; (1) past, present physical or sexual child or elder abuse (2) threat of any imminent harm to self or others (3) threat to national security (4) threat to locations: churches, theaters, schools, work places (5) court summons/subpoena/order (6) if you file insurance claim on your own, I am required to document and share your diagnosis/treatment. The Mental Health Practice Act (C.R.S. 12-43-101, et.seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf.org

Professional Relationship: (such as ours), ethical conduct guidelines dictate that our contact be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way, other than in the professional context of our therapy sessions. **Divorce and Custody:** 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 divorce or custody. My role as a therapist is not to make recommendations for the court concerning custody, parenting issues or to testify in court. This is out of my scope of practice. The court can appoint a CFI/expert, 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. In the unlikely event of time spent on legal correspondence, record requests or time away from the office due to court appearances resulting from legal issues, additional hourly fees will be assessed. My fee is $200.00 per hour. If travel is required, the fee begins from the time I leave my office until I return to my office.

Termination: As a client, you may terminate therapy at your discretion. I, too reserve the right to terminate therapy, including, but not limited to; (1) Failure to participate in therapy, comply with treatment recommendations, OR no contact for more than 60 days. (2) Clients' needs are outside of therapist's scope of competence or practice. Please consider dispute resolution. If not, upon either party's decision to terminate therapy, it is my recommendation that the client participate in at least one termination sessions. This session is intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the good work done. To ensure a smooth transition when additional therapy is needed, I will offer three 3) referrals to the client.

_____ _____

PRINT/SIGNATURE DATE

Tory L. White, M.S. Registered Psychotherapist
5080 Mark Dabling Blvd.
Colorado Springs, CO 80918.
719-247-3721

Credentials:
M.S. Marriage, Family, Child Therapy, Univ of Phoenix, 2012
Registered Psychotherapist
EMDR Certificate, 2014

Client Rights and Information required by the Board of Licensing:

a. 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 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 their profession and have two years of post-master's supervision.
   - A **Licensed Psychologist** must hold a doctorate degree in psychology and have 1 year of post-doctoral supervision.
   - A **Licensed Social Worker** 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 2,000 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 **CAC III** must have a bachelor's 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 master's degree and meet the CAC III requirements.
   - A **Registered Psychotherapist** is 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 requirements to obtain a registration from the state.

b. 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.

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

d. In a Professional Relationship (such as ours), ethical conduct guidelines dictate that our contact be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way, other than in the professional context of our therapy sessions. Colorado law requires me to inform you that in our professional relationship, physical/sexual intimacy between a therapist and a client is never appropriate and should be reported to the Board that licenses authorities; State Grievance Board, 1560 Broadway, Suite #1370, Denver Colorado, 80202, 303-894-7766.

e. Generally speaking, all information between you and therapist is legally confidential and privileged. There are exceptions; (1) past, present physical or sexual child or elder abuse (2) threat of any imminent harm to self or others (3) threat to national security (4) threat to locations: churches, theaters, schools, work places (5) court summons/subpoena/order (6) if you file insurance claim on your own, I am required to document and share your diagnosis/treatment.

f. If you are involved in divorce or custody litigation, my role as a therapist is not t 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. This is out of my scope of practice. The court can appoint a CFI/expert, 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.

g. Should you discontinue therapy for more than 45 days, your treatment will be considered "terminated" and no longer a client of Tory White. You may resume therapy at any time after such day. You may be asked to provide information to update your client records.

h. Consent for Service: Parental/guardian approval to treat minor/special needs children and myself (if applicable): This is to certify that I approve myself, my child or children's participation in therapy or programs offered through Creative Pathways Counseling & Consulting, LLC, as identified below: ☐ Marriage ☐ Individual ☐Group ☐ Family ☐ Phone

i. I have received a copy of this CLIENT DISCLOSURE STATEMENT AND CONSENT FOR SERVICES and was given time and opportunity to consider it carefully, initial all sections, ask any questions, and comprehend its contents. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to enter a therapeutic relationship with Tory L. White, M.S., and acknowledge I can end therapy at any time. Further, I understand that I can refuse any requests or suggestions made by the therapist. I am at least 15 years old or am the client's parent or guardian with legal authority to consent to treatment.

_____ _____

Print Client Name Client Signature Date

_____

Parent/Guardian (if under age 18) Date

_____

Tory L. White, MS Date