David Shanley PsyD, LLC
1776 S. Jackson St., Suite 723
Denver, CO 80210
Licensed Psychologist #4360

DISCLOSURE INFORMATION & CONTRACT FOR PSYCHOLOGICAL SERVICES

DATE: _____

CLIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE, ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

SINGLE: ___ MARRIED: ___ SEPARATED: ___ DIVORCED: ___ WIDOWED: ___

REFERRED BY: _____

MAY I THANK THIS PERSON FOR REFERRING YOU? _____

PERSON RESPONSIBLE FOR PAYMENT OF FEES: _____

HOW DID YOU HEAR ABOUT THE PRACTICE? Google _____ Psychology Today ____ Other_____

EMERGENCY NOTIFICATION: _____

PHONE: _____

RELATIONSHIP TO YOU: _____

CLIENT'S PRIMARY PHYSICIAN: _____

FOR CLIENTS 18 AND UNDER:

MOTHER'S NAME: _____ FATHER'S NAME: _____

CHILD LIVES WITH: _____ ADDRESS (if different than above:_____
_____

IF THE CHILD'S PARENTS ARE DIVORCED, PLEASE INDICATE WHICH PARENT(S) HAS(HAVE) LEGAL CUSTODY:

_____

SCHOOL: _____ GRADE: ____ TEACHER: _____

ADDRESS: _____ CITY, ZIP: _____

ADDRESS & PHONE: _____

Initials_____

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them. Once you sign this, it will constitute a binding agreement between us.

I. DISCLOSURE OF CREDENTIALS

Licensed Psychologist #4360

Master of Arts, 2010
The University of Denver
Clinical Psychology

Doctor of Psychology, 2013
The University of Denver
Clinical Psychology

II. CLIENT RIGHTS

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, and unlicensed individuals who practice psychotherapy (psychologist candidates).

The agency within the Department that has specific responsibility for licensed and unlicensed psychotherapists is the State Grievance Board, 1560 Broadway, Suite 1340, Denver, CO 80202; phone: (303) 894-7766.

As a client, you are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.

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

In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.

III. PSYCHOLOGICAL SERVICES

1. Psychotherapy (if applicable)

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems that the client brings. There are a number of different approaches that can be used to address the problems you hope to address. It is not like visiting a medical doctor, in that it requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and away from them.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger/frustration, loneliness, and helplessness. Psychotherapy often requires recalling unpleasant aspects of your history. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to significant reduction of feelings of distress, more satisfying relationships, and resolution of specific problems. But there are no guarantees about what will happen.

IV. FEES

My hourly fee is $140 (unless otherwise agreed upon that the sliding scale is appropriate). In unusual circumstances, you may become involved in a litigation that may require my participation. This will be billed at a separate rate that we will discuss.

V. CONTACTING ME

I am often not immediately available by telephone. While I am usually at work between 9 AM and 6 PM, I will not answer the phone when I am with a client. My telephone is answered by a confidential voicemail system that alerts me to all calls. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact if necessary. If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. You can also call the Rocky Mountain Crisis Line at (844) 493-8255.

VI. PROFESSIONAL RECORDS

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records, but if you wish, I can prepare an appropriate summary. Because these are professional records, they can be misinterpreted and/or be upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss what they contain. I am sometimes willing to conduct such a meeting without charge. Please note, it is my standard ethical and legal practice to maintain records for a period of 7 years after the end of treatment. After that, records may be destroyed. If you have an issue regarding your records, you must file a claim within 7 years of when the claim arose.

VII. CONFIDENTIALITY

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a registered psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

There are, however, exceptions to the general rule of legal confidentiality. In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings, delinquency proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if she/he determines the resolution of the issues before she/he demands it.

There are some situations in which I am legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm her/himself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

These situations have rarely arisen in my practice and should such a situation occur, I will make every effort to discuss it fully with you before taking action.

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important we discuss any questions or concerns you may have. As you might suspect, the laws governing these issues are quite complex, and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

VIII. BILLING AND PAYMENTS

You will be expected to pay for each psychotherapy session at the time it is held or before. Payment schedules for other professional services will be agreed to at the time these services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or installment

payment plan.

Once a fee has been set, payment is expected at the end of each office visit, unless other arrangements are made. If alternate billing arrangements are made, the outstanding balance is due and payable within ten days of the end of the month in which services were rendered.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information that I would release about a client's treatment would be the client's name, address/phone number, the nature of the services provided, and the amount due.

Appointments canceled by you without at least 24 hours notice will be charged at the set hourly fee. No charge will be made for appointments missed due to emergencies. (By their nature, emergencies do not occur frequently; if such cancellations arise frequently in the course of treatment, this would require further discussion between us.)

IX. INSURANCE REIMBURSEMENT

If you have a health benefits policy, it will usually provide some coverage for mental health treatment or evaluation. I will provide you with whatever assistance I can in facilitating your receipt of the benefits to which you are entitled, including filling out forms, as appropriate. However, you, and not your insurance company, are responsible for full payment of the fee to which we have agreed. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions, you should call your plan and inquire.

You should be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases they may share your information with a national medical information data bank. If you request it, I will provide you with a copy of any report that I submit.

It is important to remember that you always have the option to pay for my services yourself and avoid the complexities described above.

I am an in-network provider for Tricare, Anthem Blue Cross Blue Shield, and ChampVA. If you would like to use insurance to pay for services, we will discuss the details for how to make this work. Please note, you are responsible for all copays, coinsurance, and deductible payments as instructed by your insurance company. The credit card kept on file for each client may be used to cover such copays/deductible payments if no other payment arrangements are made.

If you have a Health Savings Account credit/debit card with any plan/carrier, you may pay for services with this card and no additional paperwork is needed.

X. CLIENT'S STATEMENT OF UNDERSTANDING AND AGREEMENT

Please feel free to talk with me regarding any of the information presented in this form. If you do not have any questions, after having read this form please initial each of its pages and sign below to indicate that you understand the above information and that you agree to abide by the policies indicated, including accepting financial responsibility for the above-named client. You will be given a copy of this form for your records.

By this signature, you also hereby acknowledge that you have received a copy of the "Notice of Privacy Rights."

Also, you authorize with your signature below that in the event of my death or grave disability, one or more

of my selected colleagues may review confidential information I have collected about you or your child in order to advise you of options for the continuity of treatment.

Lastly, you understand that if either one of us uses cellular or portable telephones (I use both from time to time), information transmitted by one or both of us may be intercepted by a third party. This is also the case with emails and text messages. By signing this form, you acknowledge the inherent risk in communicating via these forms of communication for scheduling and other purposes.

Consent for Treatment (Check one)

☐ I _____ voluntarily consent to mental health and/or consultative services with David Shanley, Psy.D. of David Shanley PsyD, LLC.

☐ I _____ voluntarily consent to mental health and/or consultative services for my minor child, _____ with David Shanley, Psy.D. of David Shanley PsyD, LLC.

I have read the preceding information and understand my rights as a client.

_____ _____
Signature of Client(s), Client's Guardian, or Person Assuming Financial Responsibility — Date

_____ _____
Signature of Therapist — Date
Dr. David Shanley, Psy.D.
Licensed Psychologist #4360