

Lynn McGregor, PLLC
1557 North Ogden Street, Suite 8, Denver, CO 80218
610-733-1400
lynn@lmcgregor.com

DISCLOSURE STATEMENT

Client Name: _____ Date: _____

Welcome to my practice. Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for their minor child/ren, must sign this disclosure statement on behalf of their minor child under the age of fifteen (15) years old. This disclosure statement contains the policies and procedures of Lynn McGregor, PLLC and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal Regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164). Colorado State law requires me to provide you with the following information about me:

Therapist Credentials: Lynn McGregor, MSW, LCSW

Education
Masters of Social Work,
University of Pennsylvania
Philadelphia, PA 2009

Post-Graduate
Marriage and Family Therapy
Council for Relationships
Philadelphia, PA 2011

**Gestalt Institute of the Rockies
Certified Practitioner of Gestalt
Psychotherapy, 2022**

Licenses & Certifications:
LCSW - Licensed Clinical Social
CO LIC CSW.09923567

Myers-Briggs Type Indicator (MBTI®)
Certified Practitioner, 2013
Myers and Briggs Foundation

**Psychedelic Research and Training Institute (PRATI)
Certified Practitioner for Ketamine and Psychedelic
Medicine, 2023**

Regulation of Mental Health Professionals in Colorado:

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 registered individuals who practice psychotherapy. The State Board of Social Work Examiners can be reached at 1560 Broadway, Suite 1350, Denver, CO, 80202, 303-894-7800 or 303-894-2291; DORA_MentalHealthBoard@state.co.us. The agency within the Department that has specific responsibility for Licensed Clinical Social Workers is the State Board of Social Work Examiners. Clients are encouraged, but not required, to resolve any grievances through Lynn McGregor's internal process.

Client Rights & Important Information:

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. You may seek a second opinion from another therapist or terminate therapy at any time. You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing, and given to your therapist, at any time during therapy. 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 Board of Social Work Examiners. Closure is an important part of therapy and at the termination of counseling, a closing session is requested.

Confidentiality:

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or a registered psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado Statutes (see 12-43-218, C.R.S.). You should be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you as the situations arise during therapy. The Mental Health Practice Act (CRS 12-43-101, it seq.) is available at: <http://www.dora.state.co.us/mental-health/Statute.pdf>

You should be aware that 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. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. 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 a third-party. Please review and fill out the Consent for Communication of Protected Health Information by Unsecure Transmissions.

Confidentiality in Couples, Adolescent & Family Therapy:

In couples and/or family counseling, the "couple" or the "family" are consider the "client" rather than individuals. Each individual is a member of the client and make up the client as a whole. Given that the "client" in couples and family counseling consists of more than one person, I have a "**no secrets**" policy. At times, instances arise where one partner, or a family member, wants to tell me something without the other knowing about it. This means that if information is critical to therapy, we would discuss the best way for this to be discussed in couples or family work. Please be aware that information you choose to share with me that is particularly pertinent to the other members may come out in counseling. This pertains to all face-to-face, written, and phone conversations and messages. **I cannot be subpoenaed to testify or produce records without consent and authorization from all parties.** Each member of a couple or family unit is required to sign this disclosure statement.

For adolescents 15-17 years old, information shared by the adolescent in counseling is confidential. However, in my sole discretion I may disclose to parents of the services given or needed by the adolescent, with or without the adolescent's consent. Adolescents need to be aware that there may be times when information shared needs to come out in family therapy with parents present and they will be guided & supported to do so. Work with adolescents is generally more productive if parents voluntarily agree to not request information about the content of the adolescent's private session other than about general progress and response to treatment.

Consultation:

There may be times when I may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by you in therapy. Your confidentiality is still protected during consultation between me and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client. You will need to sign a separate Authorization for Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney retained by me.

Extraordinary Events:

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.

Frances Forgione
Licensed Clinical Social Worker, Colorado, #959
Licensed Addiction Counselor, Colorado, #367
Tel: 303-919-4093

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.

Electronic Records

I may keep and store records for each client electronically on my laptop or desktop computer, and some mobile devices. In order to maintain security and protect the record, I employ the use of firewalls, antivirus software, changing passwords regularly, or encryption methods to protect computers and/or mobile devices from unauthorized access. I can also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

I may also use electronic backup systems either by using external hard drives, thumb drives, or similar methods; this includes the email service provider I use. My email service provider is: 1 & 1. This helps prevent the loss or damage of records. I maintain the security of these backup devices through encryption and passwords. I have entered into a HIPAA Business Associates Agreement with my email service provider, which obligates the email service provider by federal law to protect these records from unauthorized use or disclosure. It may be necessary for other individuals to have access to these records, such as the email service provider's workforce members, in order to maintain the system itself. Federal law protecting the records extends to these workforce members. If you have any questions about the security measures I employ, please ask.

Social Media

I do not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. If you have any questions regarding social media, review websites, or search engines in connection to your therapeutic relationship, please contact me immediately and address those questions.

Non-Emergency Services:

I provide non-emergency therapeutic services **by scheduled appointment only**. If, for any reason, you are unable to contact me by telephone number I provided you and listed above, and you are having a true emergency, call 911, check into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. I do not provide after-hours service without an appointment. **If you must seek after hours treatment from any counseling agency or center, you understand that you will be solely responsible for any fees due.** If you leave a voicemail for me on the number provided above, I will return your call by the end of the next business day, excluding holidays and weekends.

Fees:

Payment by cash, check, or credit card is due at the beginning of each session. To make the most of our time together, please make out your check to Lynn McGregor, PLLC in advance and give at the beginning of the session.

\$175 per 55-minute session, individual therapy

\$250 per 90-minute session for couples or family therapy

\$250 per 90-minute session for Focused EMDR, MBTI Interpretive Session, Intensives

\$40.00 per 15-minute interval phone therapy

Brief 5-10 min. phone calls are allowed without charge on a limited basis.

If you are in need of financial assistance, please discuss this with me and I will try to accommodate you. Assistance is based on household income and may require documents to verify income. Adjusted rate: _____

Initials: ____ (Client) ____ (Therapist)

Court testimony and other legal related matters are charged at a higher rate. These services include but are not limited to: attorney fees I may incur in preparing for the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is \$350.00 per hour.

It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

Therapy fees and treatment are based on a 55 or 90-minute clinical hour so that I may review my notes and assessments on your behalf.

I am not a Medicaid provider. If you have Medicaid coverage that includes mental health services, I am not able to offer mental health services to you.

Insurance and Third Party Payors:

Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timeliness to your insurance company. If you would like to submit your counseling service charges to your insurance company, a statement of charges can be provided for you to submit for possible reimbursement for your work with me as an out-of-network provider. **Please note that it is your responsibility to complete and file any insurance paperwork.** If you elect to use your health insurance plan to assist in the payment of treatment, your insurance carrier and the National Information Center will have access to your diagnosis code and other pertinent data needed for claim processing.

My insurance provider is: _____

I will need an invoice to submit to my insurance company. Yes ____ No ____

Initials: ____ (Client) ____ (Therapist)

Maintenance of Client Records

As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of The State Board of Social Work Examiners, I will maintain your client record for a period of (7) years after the termination of therapy or the date of our last contact, whichever is later. I cannot guarantee a copy of your Client Record after this seven-year period.

Cancellations:

It is understandable that at times it may be necessary to cancel an appointment. To help to insure efficient and responsible use of time, any changes or cancellations must be made at least 24 hours in advance. **Any changed, cancelled, no-show, or missed appointment with less than 24-hour notice may be charged the regular fee.** Exceptions *may* be made in emergency situations.

Additional Information:

There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

Because of the nature of therapy, you understand that our therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of psychotherapist and client. This means that I cannot be your friend, have any type of business relationship with you other than the counseling relationship, I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and I cannot hold the role of counselor to my relatives, friends, the relatives or friends, people I know socially, or business contacts.

If you are consenting to treatment and therapy services for your minor child/ren, I request you provide the Court Order Custody Agreement and/or Parenting Plan that grants you the authority to consent to mental health services for your minor child. Further, you understand and agree to keep me informed of any proceedings or supplemental court orders that affect your parenting rights, custody arrangements, and decision-making authority. You understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit me from providing therapy to your minor child/ren. You understand that it is beyond the scope of my practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date. You understand that you have received my Notice of Privacy Policies and Practices, and acknowledge receipt of the policy.

Client Contact and Communication

I give Lynn McGregor, LCSW, the permission to contact me for scheduling, billing statements, sending psycho-educational information, sharing resources and referrals through the following means. I agree not to send personal, confidential information through these means, and I understand the risks of electronic transformation of information.

(Please initial any forms of communication for which you give permission.)

- Leave a message at phone number(s) _____
- Leave a text at phone number _____
- Send ground mail to address: _____
- Fax information to fax number _____
- Send email to email address: _____

By signing below, I authorize services and will pay all fees. Lynn McGregor, PLLC reserves the right to send clients with unpaid fees to collections. I have been informed of the therapist's credentials and understand my client rights.

_____ Date _____
Client Signature

_____ Date _____
Client Signature (Spouse for Couples Therapy)

_____ Date _____
Therapist Signature