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 eighteen (18) 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 eighteen (18) years old. This disclosure statement contains the policies and procedures of Lynn McGregor, PLLC. 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

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

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

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

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

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.

A Licensed Clinical Social Worker must hold a master's degree in their profession, have two years of post-masters supervision, pass an examination in their profession, and pass the Colorado jurisprudence examination.

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. Your records may be destroyed after seven years in accordance with Colorado law. Please see the "Maintenance of Client Records" section below for more information.

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 an unlicensed 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 12-245-2220, 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 12-245-101) is available at:
http://www.dora.state.co.us/mental-health/Statute.pdf

For example, I am required to report known or suspected 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, neglect, 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.

Please be advised that there is no time limit on mandatory reporting of child abuse. This means that even adult clients who experienced childhood abuse (no matter how long ago) might disclose in therapy past abuse incidents that still fall under the mandatory reporting requirements. The law requires that if there is reasonable cause to know or suspect that the perpetrator has subjected any other child currently under eighteen years of age to abuse or neglect or to circumstances or conditions that would likely result in abuse or neglect and/or is in any "position of trust" with children today, then past abuse disclosed by an adult client is required to be reported. If you have questions or concerns about the requirements, please discuss further with me.

Please note that if we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. If you acknowledge me first, I will be more than happy to speak briefly with you, however, I will not engage in any lengthy discussions in public or outside of the therapy office.

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 considered 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. If one member of the couple or family discloses information that is directly relevant to the treatment of the couple or family, in most cases, that information will become part of the record which can be accessed by other members of the family or couple, and the information will likely be shared in a session with the other members of the couple or family for the sake of facilitating treatment. I will use my best judgment in deciding when or if such disclosures will be made, and whenever possible, I will give you the first opportunity to share the information yourself. In addition, if a request is made for the record of couple or family therapy to be disclosed to a third party, records will only be released with the consent of all adult parties, and any information that is released to a third party or to an individual within the couple or family will be released to both members of the couple or to all adults engaging in family therapy. **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.

If you are consenting to the treatment of a minor child, you will be required to provide a copy of the most recent Court Order Custody Agreement and/or Parenting Plan, if applicable, that gives you the authority to consent to the treatment of the child. By sighing this form, you agree to keep me informed of any supplemental court orders or other proceedings that impact your parental rights, custody arrangements, or decision-making authority. Failure to produce the Court Order will prohibit me form seeing the minor child. If there is joint medical decision-making authority for your child, I will require both parents to consent to treatment and will not proceed until such consent is obtained.

It is beyond the scope of my practice to provide custody recommendations and any such requests will be denied. The Court can appoint professionals who have the expertise to make such recommendations. By signing this below, you agree not to subpoena my records or ask me to testify in court or to provide letters or documentation expressing my opinion about custody or visitation. Despite this, a court may still require me to testify or to provide treatment information to an evaluator. I will comply with these requests as legally required, and you will be required to compensate me for time spent providing these services as indicated in the "Fees" section below.

In the course of treatment with your child, I may involve other family members in your child's treatment. However, please remember that my client is your child, not the other family members of the child. Any meetings with you or other family members will be documented on your child's record. These notes will be available to anyone who has legal access to your child's treatment record. When treating a minor client where there is a custody agreement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email (i.e. all communication will be "cc" both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the minor client.

Therapy is most effective when there is a trusting relationship between the therapist and client. Privacy is important in establishing trust, and as a result, it is often important for child and adolescent clients to have a level of privacy around the therapy. It is my policy to provide parents with general information about their child's treatment, but not to share specific information disclosed in therapy. This may include behaviors that you may not approve of, but which do not place your child at imminent risk or danger. If I ever feel that your child is in danger, I will communicate the information to you. By way of example, if your child tells me that that they have tried alcohol a few times at parties, I will not generally share this with you. If your child shares that they have been drinking and driving, or riding with a drunk driver, I would share this information with you. If you have questions about the types of information I will share, you can feel free to ask me hypothetical questions about situations that I would or would not disclose to you.

Although you may have legal right to access any written record I keep, by signing this agreement you are agreeing that your child or adolescent should have privacy in therapy and you agree not to request access to your child's full record.

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 Communications
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 utilize reasonable security measures, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. By initialing below, you consent and authorize me to communicate Protected Health Information ("PHI") through the following unsecure transmissions (please initial all of your choices):

_____ Cellular/Mobile phone, including text messages and voicemails
Cell number: 610-733-1400

_____ Unsecured email
Email: lynn@lmcgegor.com

Client's email address:_____

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.

I also charge $175 per hour for other professional services such as report writing, telephone calls, preparation of reports or treatment summaries, meeting with other professionals with your authorization, and time spent performing services your request of me. Please be aware that insurance companies may not provide reimbursement for these administrative services and you may be personally responsible for the payment of such fees. Please note that I do not provide Emotional Support Animal (ESA) letters, or disability paperwork, letters or disability paperwork for therapy clients, as this is beyond my scope of practice. Fees are subject to change periodically, and I will notify you in advance of any such fee increase.

.
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)

As a general rule, I do not get involved in legal proceedings as this can have a negative impact on our therapeutic work together and is outside the scope of my role as a treating therapist. If you become involved in legal proceeding and compel me to participate through a subpoena or court order, I charge $350 per hour for services related to your legal matter. You will be responsible for paying for any professional time I spend on your legal matter, even if the request comes from another party. Professional time spent on your legal matter includes, but is not limited to: attorney fees that I may incur in preparing for or complying with the requested legal services: testimony related matters such as a case research, report writing, travel, depositions, actual testimony, cross examination, and courtroom waiting time. Please note that I will not provide evaluations or expert testimony in court. Such services should be provided by an outside provider in order to preserve our therapeutic relationship

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. By initialing below, you are confirming that you are not currently a Medicaid recipient and that you agree to notify me if that status changes.

_____ (initials)

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. When the client is a child, the records must be maintained for a period of seven years commencing either upon the last day of treatment or when the child reaches 18 years of age, whichever comes 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.

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