# I Counseling Solutions, LLC

*David Gertz, MS, NCC*
*4500 E. 9th Ave. Suite 660*
*Denver, CO, 80220*

## CLIENT – THERAPIST AGREEMENT

The practice of licensed, registered, or unlicensed persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Divisions of Registrations at: 1560 Broadway Street; Suite 1350; Denver, CO 80202; 303-894-7800.

- ❑ The Board of Licensed Professional Counselor Examiners
- ❑ The Board of Marriage and Family Therapists Examiners
- ❑ The Board of Psychologist Examiners
- ❑ The Board of Social Work Examiners
- ❑ The Board of Registered Psychotherapists (unlicensed psychotherapists)
- ❑ The Director of the Division of Registrations, Office of Addiction Counselors (303-866-7400)

**CLIENTS RIGHTS:**
You are entitled to receive information about methods of therapy, the techniques used, the duration of therapy if known, and the fee. You may seek a second opinion from another therapist and may terminate therapy at any time. In a professional therapy relationship, sexual intimacy is never appropriate and is illegal in Colorado. It should be reported to the appropriate Board or Division listed above.

**CONFIDENTIALITY:**
The information provided by you during therapy is legally confidential except as required by law. There are exceptions to the rule of confidentiality. In general, these exceptions include:

1. The law requires reporting cases in which:
   - the client may present a danger to self or others,
   - there is indication of child abuse or neglect.

2. Therapist(s) and/or records may be subpoenaed in Court proceedings including but not limited to child custody, criminal, and delinquency cases.

If legal exceptions arise regarding confidentiality and if feasible, these exceptions will be discussed with you.

**APPOINTMENTS:**
Therapy sessions are 60 minutes. This time is reserved for you. In the case that you need to cancel or reschedule an appointment, 24-hour advance notice is required. With less than 24 hours notice, you will be charged the full amount for the session. This will be your responsibility and cannot be charged to insurance.

**FEE:**
The full fee for a 60-minute session is $ 90.00 for couple/family sessions and $75 for individual. Your fee/copayment is _____, due in full at each session.

Have your cash or pre-written check ready prior to the beginning of each session. Fees may be renegotiated every six months or whenever your income changes. If you end therapy with an unpaid balance and do not make arrangements to settle the bill, your account may be turned over to a collection agency. Any costs incurred in the collection are your responsibility.

Telephone conversations of a clinical nature may be charged as regular sessions. Reports and court appearances require professional time for which we charge the full rate of $125.00; court appearances require 4-hour minimum.

**(OVER)**

**TREATMENT PLANNING AND EVALUATION:**
Since i Counseling Solutions, LLC is not a 24-hour crisis-intervention agency, in case of an emergency, you may call the numbers on the accompanying EMERGENCY NUMBERS sheet, or you may call 911 or go to the nearest hospital emergency room.

Your therapist can approximate length of treatment and probable results; however, as response differs on an individual basis, guarantees cannot be made as to treatment outcome. If we cannot provide the services you need, your therapist will offer you referral information.

Periodically, client and therapist will assess progress toward treatment goals. It can be mutually beneficial if termination is discussed in advance.

*** * * * * * * * * ***

I have received a copy of the NOTICE OF PRIVACY PRACTICES. _____Client initials

I have been given a copy of this CLIENT-THERAPIST AGREEMENT, a list of EMERGENCY NUMBERS, and a PERSONAL DISCLOSURE STATEMENT of my/my child's therapist's name, degrees, credentials and licenses. I have read the preceding information; it has also been provided verbally. I understand my rights as a client or as my child's responsible party. I consent to treatment at i Counseling Solutions, LLC.

| | | | |
|---|---|---|---|
| Adult Signature | Date | Teen Signature (ages 15-18) | Date |
| Adult #2 Signature | Date | Therapist Signature | Date |

**FOR FAMILIES:**

Name(s) of Client(s) if minors

❑ **I attest that I am authorized to give permission for my child(ren) to have counseling at i Counseling Solutions, LLC.**

| | | | |
|---|---|---|---|
| Parent/Guardian Signature (of children age 14 and under) | Date | Parent/Guardian Signature (of children age 14 and under) | Date |
| Therapist Signature | Date | | |