BELIEVING IN KIDS & FAMILIES
COUNSELING SERVICES
SUE E. COFFEY, LCSW
POLICY STATEMENT

The following items are policies that are particular to the manner in which I do counseling. Please read each item and initial on the space provided to indicate you have (a) read the policy item and (b) understand the intent of it. Please feel free to discuss any or all of the policy items with me.

________ I or we have received this clinician's statement of therapeutic orientation.

The Benefits and Risks of Counseling

As with any treatment, there are benefits as well as risks. The benefits may include improved personal relationships, clearer personal goals and values, and you may find greater satisfaction in your life. On the other hand, as individuals progress through counseling they may discuss unpleasant memories or feelings. Most of these risks are expected and making important changes in your life may be challenging. Finally, even with both parties making their best efforts, counseling may not work out for you. I am available to discuss any of your assumptions, problems, or possible negative side effects in our work together and enter the counseling relationship with optimism about your progress. Please be aware that touch can be an important therapeutic tool for children, teenagers, and adults. Examples can be playing little piggies, high fives, and hugs.

________ I or we understand the benefits and risks of counseling.
________ I understand that touch may be used as a therapeutic tool.

Confidentiality

I have a legal and moral duty to protect your confidentiality. We also have a duty under the law to the wider community and to ourselves, if there is harm, threat of harm, or neglect. This topic of exceptions to confidentiality is further discussed in this clinician's disclosure statement. Finally, if for some reason there is a need to share information in your record with another person, such as a clinician or physician, you will be asked to sign a release of information.

________ I or we understand the confidentiality piece of the counseling relationship.
________ I or we have received this clinician's disclosure statement.

Appointments

I need for you to give 24-hour notice if you need to cancel an appointment. Please be aware that you will be charged for appointments that you do not cancel 24 hours prior to the scheduled session. Appointments are scheduled as 50-minute sessions for counseling. Please be aware that this includes meeting with a child/teen and a parent or parents. The 50-minute session is divided with 30 to 40 minutes for meeting with the child/teen and the remainder of the 50-minute session is to meet with the parent(s). Please be aware that if you are late to an appointment we may not be able to complete a full scheduled session, as there are often sessions scheduled directly after your appointment. You will be charged for the full session even if you are late to the appointment. If you have insurance or another form of third party paying for appointments, please be aware that they often do not pay for late arrivals or missed sessions. This includes victim compensation benefits.

________ I or we understand the policy concerning appointment length, lateness, and need to give 24-hour notice.

Fees, Payments and Billing

The fee for the services of individual, family and couples counseling is $105.00 per hour. Group counseling is $40.00 per session. For work outside the office, such as hospital or school visits, I charge the individual rate "portal to portal"- that is for the time the clinician leaves and returns to the office on your behalf. If a full, hourly session is outside of your budget, another option available to people is paying for ½ a session or 25 minutes, totaling $52.50. This clinician recommends at least ½ a session to allow work to be done towards goals. Once the fee is established you will be asked to honor this agreement and pay for services at the beginning of each scheduled session.

This clinician charges for court appearances on your behalf. The hourly rate is $105 and starts from the moment your clinician leaves the office to the time the clinician returns, this includes when court proceedings are delayed or do not occur and are rescheduled for another date.

Please clarify at the point of scheduling an initial appointment, whether you will need for a clinician to conduct an assessment for court proceedings and what the nature of the court proceedings are. This clinician makes every effort **not** to take on duplicate roles within one family (for example, expert witness and therapist to child, therapist to child and therapist to family).

Full payment is expected at the time of service. For this reason outstanding balances are not permitted and services cannot be offered until an outstanding balance is paid-in-full. Please be aware this includes co-pays. You are responsible for fees accrued for a returned check for the first incident. Should there be a subsequent incident of a returned check, then you will be expected to pay in cash for services from that point on. Insurance: It is best for you to contact your insurance provider and discuss your benefits. This clinician will submit billing for your reimbursement of fees paid.

Finally, all of the professional time of this clinician will be billed, and prorated for services that extend beyond 10 minutes. This includes report preparation; letters on your behalf, insurance company paperwork, and telephone calls. All professional time of this clinician will be billed for at the $105 rate (prorated by minute). If you are pursuing benefits through Victims Compensation, 18th Judicial District and/or Juvenile Probation, Senate Bill 94, or any other third-party, then **please be aware that case management services and report-writing are not reimbursed by these entities and will be your responsibility to pay for these services.**

__________ I or we understand the fees for services, the methods of payment and when, as well as what services I will be billed for by my clinician.

Emergencies and After-Hours/Unscheduled Counseling Contacts

This clinician limits after-hours work, as clients are encouraged to take the necessary steps to care for themselves, so does this clinician. This clinician cannot assume responsibility for your (or your child's) day-to-day functioning, as does an institution, such as a mental health agency, inpatient hospital, or day treatment setting. For this reason, clients are assumed to be self-responsible and not in need of day-to-day supervision.

Clients are encouraged to discuss any expectations of after-hours or emergency care with the clinician upon intake, so if necessary, an appropriate referral can be made.

Mental Health Corporation of Denver- 303-377-4300
Arapahoe/Douglas Mental Health Network- 303-795-6187
Aurora Mental Health-303-617-2300

Further, if there is an emergency during our work together, or if I become concerned about your personal safety, I am required by law and the rules of my profession to contact someone close to you. I am also required to contact this person if I become concerned about you harming someone else.

Please write down the name and information of your chosen contact person in the blanks provided:
Name:____
Relationship to you :____
Address: ____
Phone: ____

__________ I or we understand the emergency and after-hours/unscheduled counseling contacts policy.

__________ I or we understand that in cases of a behavioral or emotional emergency or crisis, you or one of your family members can go to the nearest hospital emergency room, you should call one of the following community emergency agencies or **911**.

Our Agreement

I/We, ___________________________________, understand I have the right not to sign this form. I/We, the client or parent/guardian, have discussed any concerns with you, the clinician. I/We understand that once counseling begins I/We have the right to withdraw at any time. However, I/We will make every effort to discuss my concerns about my counseling before terminating counseling services.

I/We understand that no specific promises have been made to me by this clinician about the results of treatment, the effectiveness of the procedures, or the number of sessions required for counseling to be effective.

I/We agree to act accordingly to the points covered in this policy statement and agree to enter into counseling with this clinician as shown by my signature here.

____ ___________________
Signature of client (or person acting for the client) Date

____
Printed name (*Relationship to client: __self __parent/guardian __Other person authorized to act on behalf of the client)*

I, the clinician, have met with this/these client (and his/her parent(s) or guardian(s)) for a suitable period of time and have informed him or her of the issues covered in the policy statement. I have responded to his or her questions and believe this person fully understands the issues and policies discussed in this policy statement.

__________________________________ ______________
Signature of Clinician Date