

## PROFESSIONAL DISCLOSURE AND CLIENT RIGHTS STATEMENT

Counselors at the Regis University Thornton and Colorado Springs Counseling Centers are master's level counselors-in-training enrolled in Practicum. Among requirements for their course is a series of 45-minute counseling sessions; which will be recorded for use during individual and group supervision. Sessions may be viewed as they occur (via one-way mirror or video feed) by a faculty supervisor and other counselors-in-training enrolled in practicum. After sessions, recordings will be reviewed with the faculty supervisor and course colleagues, and the recordings will be destroyed by the end of the semester. These recordings are for educational purposes only and will not be added, attached or compiled with your medical or client records. The counselor-in-training may also prepare a verbatim transcript that will provide another opportunity for improvement of counseling skills.

You are entitled, to receive information from the counselor-in-training (or supervisor) about the methods of therapy and the techniques used. Therapy sessions will take place at the same time weekly during the 16-week semester. Near the end of the semester, you will discuss termination, referral(s), and/or continuing at the center next semester with a different therapist. You can seek a second opinion from another therapist or terminate therapy at any time.

Faculty supervisors and counselors-in-training will regard everything you say or reveal during sessions in a professional manner. However, because of the nature of this experience, the limits of confidentiality typically assured for clients will be broadened to include supervisors and fellow trainees. It would be unprofessional if any of supervisors or counselors-in-training discussed the interaction with any person outside of the class group. Additionally, in a professional relationship (such as ours) sexual contact between client and therapist is never appropriate and is illegal in the state of Colorado. It should be reported to the Department of Regulatory Agencies (see contact information below).

Information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and cannot be disclosed without written consent. There are certain legal exceptions to confidentiality that may include, but are not limited to, a court order or subpoena. Counselors-in-training are also required to:

1. Report child abuse or neglect to the Department of HHS and/or law enforcement;
2. Report the abuse and exploitation of elders, 70 years of age or older (C.R.S. 18-6.5-108);
3. Release information when court ordered to do so;
4. Report when there is a legal duty to warn of a threat from a client of imminent physical violence and/or when a client is a "danger to self or others" (C.R.S. 27-65-102(4.5));
5. Release information when there is a "condition in which a person as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people" (C.R.S. 27-65-102(9));
6. Release information when required to report a threat to the national security of the U.S.; and
7. Release information when a therapist needs to request a "Welfare check through law enforcement" in the event that the therapist becomes concerned about the client's safety/welfare.
8. There is a "duty to warn: ... where the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity" (C.R.S. 13-21-117);
9. Where there is a duty to warn, the mental health provider: "... shall make reasonable and timely efforts to notify the person or persons, or the person or persons responsible for the specific location or entity that is specifically threatened," (C.R.S. 13-21-117).

Note that ONLY authorized persons will have access to your records. If you return to the clinic for future counseling, your records may be reviewed by the new trainee and their supervisor. At the completion of your counseling, these records will be filed in the HIPAA secure server for seven years, after which they will be erased.

**PROFESSIONAL DISCLOSURE AND CLIENT RIGHTS STATEMENT**

**Please also review the following:**

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Registered Psychotherapist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202; 303.894.7800. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

**EMERGENCIES:**

The Regis Center for Counseling and Family Therapy operates as a training facility, with NO emergency services.

**FEE AND PAYMENT POLICY:**

In order to support our continued operations we ask clients to pay a small fee for our services. However, if at any time you are unable to pay your fee, or if you need to renegotiate the fee of the services you are receiving, please let your counselor or therapist know. You will not be turned away for services for an inability to pay.

Please pay for services prior to the beginning of your session. We are able to accept cash, checks or credit card payments.

**CANCELLATION POLICY:**

Cancellations must be made by calling either the Thornton Center at 303.964.5786 or the Colorado Springs Center at 719.264.7027 at least 24 hours in advance.

*I acknowledge that I have read and received a copy of the Professional Disclosure and Client Rights information.  
I understand my rights as a client.*

\_\_\_\_\_  
Client (print name)

\_\_\_\_\_  
Faculty Supervisor (print name)

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_\_\_  
Faculty Supervisor Degrees/Licensure

\_\_\_\_\_  
Counselor-in-Training (print name)

\_\_\_\_\_  
Faculty Supervisor Signature

\_\_\_\_\_  
Counselor-in-Training Signature

\_\_\_\_\_  
Date

**CONSENT TO TREATMENT OF MINOR CHILD**

Legal name of minor child: \_\_\_\_\_

I, \_\_\_\_\_, as parent or guardian of my minor child, hereby affirm that I have been assigned parental responsibilities to consent for health care by the state of Colorado for my minor child and I hereby give consent for my child to receive counseling by a graduate student in training at Regis University.

I understand that only the therapist, supervisor(s) and other students in their class will know the information learned during the course of therapy. (Please read Patient Rights Form for exceptions.) Furthermore, I understand Regis University is under no obligation to release any information related to my child's therapy to other persons or agencies.

I understand that the student conducting this therapy will be doing so under the supervision of his/her professor and that to facilitate this supervision, therapy sessions with my child and collateral sessions with me will be videotaped.

I understand that when parents or unmarried or divorced, Colorado law allows any parent who has been assigned parental responsibilities access to medical records. Therefore in compliance with C.R.S § 14-10 123.8, I authorize the graduate student in training to provide access to treatment information to such an individual by authorizing me to provide services to a child in your custody.

I was informed during the initial intake and I understand that Regis University student counselors and supervisors DO NOT agree to testify in court. If I am involved in a divorce or custody litigation, I understand that the role of the graduate student counselor in training is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this disclosure statement, I agree not to call the assigned student counselor as a witness in any such litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between therapist and client. Only court-appointed experts, investigators or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. *(Adapted from Lane, 2009).*

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## HIPPA PRIVACY POLICIES AND PROCEDURES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent revisions including the HITECH Act requires that all health care records and other individually identifiable health information (PHI) used or disclosed to us in any form be kept confidential and secure. This federal law provides you, the patient or employee, with significant rights to understand, control, and have access to your health information and includes penalties for any misuse of that information.

During the process of providing services to you via the Regis Health Plan, Counseling Services, Regis Cares PT Clinic, Beach Court Elementary School, or other entities, confidential information (mental health, medical information, etc.) will be gathered and stored on a HIPAA secure server maintained by Regis ITS department for uses described within this notice and will not be disclosed without your consent except for the circumstances described in this Notice.

### Uses and Disclosures of Protected Information:

Specific written authorization is not required for the purposes of treatment, payment and health care operations as defined below:

1. **Treatment:** Refers to the provision, coordination or management of mental health, medical care and any treatment plan processes. Those involved in treating an individual may use your information to plan your course of treatment, consult with other health care professionals or their staff including health care students concerning services needed or provided to you.
2. **Payment:** Payment refers to the activities undertaken by a health care provider/plan to obtain or seek reimbursement for health care services which may involve disclosures to insurance companies or to third party billers for assistance in obtaining payment.
3. **Health Care Operations:** Health care operations refers to activities undertaken by an entity that may include access to information for management and administrative purposes, quality assurance, medical and/or legal reviews, audits, compliance, business planning, accreditation or credentialing activities.

### Disclosures Required by Law:

Regis University will disclose protected health information when required by law. This includes but is not limited to:

1. Reporting child abuse or neglect to the Department of HHS and/or law enforcement;
2. Reporting the abuse and exploitation of elders, 70 years of age or older (C.R.S. 18-6.5-108);
3. When court ordered to release information;
4. When there is a legal duty to warn of a threat from a client of imminent physical violence and when a client is a "danger to self or others" (C.R.S. 27-65-102(4.5)), therapists can require a 72-hour hold and/or hospitalizations. Beach Court Elementary School holds a policy regarding the ability to disclose confidential information to request a "Welfare check through law enforcement" in the event that the therapist becomes concerned about the client's safety or welfare;
5. When there is a "condition in which a person as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people" (C.R.S. 27-65-102(9));
6. When required to report a threat to the national security of the U.S.;
7. There is a "duty to warn: ... where the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity" (C.R.S. 13-21-117);
8. Where there is a duty to warn, the mental health provider: "... shall make reasonable and timely efforts to notify the person or persons, or the person or persons responsible for the specific location or entity that is specifically threatened," (C.R.S. 13-21-117).

## HIPPA PRIVACY POLICIES AND PROCEDURES

### Other Uses:

1. Protected health information concerning you may be used with your permission for research purposes if the relevant provisions of the Federal HIPAA privacy regulations are followed.
2. Protected health information and compliance documents may be used with your permission to arrange clinical site placement.

### Your Rights:

1. Access to Protected Health Information: You have the right to receive copies of your health information by contacting the service provider directly and completing the appropriate request.
2. Amendment of Records: You have the right to request an amendment to your health record if you believe information to be inaccurate or incomplete by contacting the service provider directly.
3. Disclosures: You have the right to request an accounting of disclosures of your records by contacting the health provider directly and completing the appropriate request form.
4. Report Privacy Violations: If you feel that your health information or privacy has been compromised (either electronically or verbally), you may send a written complaint to the US Department of Health and Human Services at the address below and/or contact the Regis University Privacy Officers listed below.

#### **US Department of Health & Human Services**

Office of Civil Rights  
200 Independence Avenue, SW  
Washington, D.C., 20201  
Phone: 877-696-6775 (Toll Free)

#### **Regis University Privacy Officers:**

Susan Layton (slayton@regis.edu)  
Sheila Carlon (scarlon@regis.edu)

**CLIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES**  
(You may refuse to sign this acknowledgment)

I/We, \_\_\_\_\_ have received a copy of the Regis University Notice of Privacy Practices with an effective date of April 14, 2003.

Name of client(s) or parent/ guardian of minor child: \_\_\_\_\_

Address of client(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Client(s) or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Client(s) or Personal Representative Authority

\_\_\_\_\_  
Description of Personal Representative Authority  
(Attach document evidencing authority, such as Power of Attorney)

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

**FOR OFFICE USE ONLY**

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

- Patient/Individual refused to sign (Date of refusal) \_\_\_\_\_
- Communications barriers prohibited obtaining an acknowledgement
- An emergency situation prevented us from obtaining an acknowledgement
- Other: \_\_\_\_\_

Attempt was made by \_\_\_\_\_

Date \_\_\_\_\_

Explain \_\_\_\_\_





**CLIENT INFORMATION FORM**

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Name of Guardian (if minor) \_\_\_\_\_ Referred by \_\_\_\_\_

DOB and Age \_\_\_\_\_ Gender Identification \_\_\_\_\_

Occupation \_\_\_\_\_

Phone Number(s) \_\_\_\_\_ Permission to leave voicemail? **YES NO**

Email \_\_\_\_\_ Permission to email? **YES NO**

Home Address \_\_\_\_\_

**Marital Status:**

**Ethnic Origin:**

- Single
- Married/Living with Partner
- Separated
- Divorced
- Widowed
- Single Parent
- White/Euro-American
- Asian/Asian-American
- Black/African-American
- Hispanic/Latino(a)
- Native American/Indian
- International
- Biracial
- Other: \_\_\_\_\_

Previous Counseling? **YES NO** Name of Agency/Private Therapist \_\_\_\_\_

Dates/Reasons for previous therapy \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications \_\_\_\_\_  
\_\_\_\_\_

Health problems \_\_\_\_\_  
\_\_\_\_\_

Do you drink alcohol? **YES NO** How often/much do you drink \_\_\_\_\_

What non-prescribed drugs are you taking? How often/much do you take? \_\_\_\_\_

**My use of alcohol/drugs has caused:**

- Traffic ticket/violation
- Ruined a relationship
- Black outs
- Trouble with the legal system
- Fight with a friend
- Academic problems
- Dicipinary action
- Other: \_\_\_\_\_

Are you concerned about your drug/alcohol use? **YES NO**

Are your friends/family concerned about your drug/alcohol use? **YES NO**



