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Sharon Gusmus: MA / LPC / CAS

DISCLOSURE, TREATMENT, AND FEE AGREEMENT

Degrees and Credentials: LPC, CAS, EMDR trained, Masters of Arts Student in Counseling, Bachelors of Arts in Biblical Studies Associates of Applied Science in Early Childhood Education

Regulation of Psychotherapists:

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 regulatory boards can be reached at 1560 Broadway, Suite #1350, Denver, Colorado 80202, (303) 894-7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a Masters degree in their profession and have two years of post-Masters 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 Masters 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 1,000 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 Bachelors 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 Masters degree and meet the CAC III requirements. A Registered Psychotherapist is listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the State and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

Client Rights and Important Information:

Method of Treatment: You may receive information about the methods of treatment, techniques used, duration of therapy if known, and the fee structure. At any time, you may seek a second opinion or terminate treatment. Please be advised that in a professional relationship, sexual intimacy is never appropriate and should be reported to the Department of Regulatory Agencies.

Sessions and Fees: Sessions are typically 50 minutes in length and are billed at $195 per session; upon request, or 90-minute sessions (billed at $255 per session) may be available. Payment for each session is due at the time of each therapy session. Some insurances are accepted, ask for details. You will be billed $50 for missed sessions unless you cancel at least 24 hours prior to your scheduled session. There is a $30 processing fee for checks returned for “non-sufficient funds.” Written reports or other services may be available for an additional charge. Court appearance is not something offered, however if a court order is placed and I am required to appear in a legal proceeding for a current or former client, a $750 non-refundable minimum fee will be assessed, due prior to preparation and appearance. When preparation and/or appearance exceeds 8 hours, you will be charged my normal hourly rate, including travel time, payable upon receipt.

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Confidentiality: In general, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client’s consent. Exceptions to confidentiality include the following: (1) I am required to report any suspected incident of child or elder abuse or neglect; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled as a result of a mental disorder; (4) I am required to report any observation of abuse or exploitation of an at-risk elder (70 years and older), or if I have reasonable cause to believe that an at-risk elder has been abused or has been exploited or is at imminent risk of abuse or exploitation, to law enforcement (5) I am required to report any suspected threat to national security to federal officials; and (6) I may be required by court order to disclose treatment information.

When I am concerned about a client’s safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this statement and agreeing to treatment with me, you consent to this practice if it should become necessary.

Emergencies: In a mental health emergency, dial 911 or go to your nearest urgent care or emergency center. Non-emergency calls will be returned by the therapist within 1 business day.

Regarding Divorce and Custody Litigation: If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

I understand and agree to the conditions stated above, including policies regarding fees, insurance, cancellations, confidentiality, crisis coverage, and client rights. I also hereby acknowledge that I have received a copy and/or accessed the electronic copy of the provider's Notice of Privacy Rights.

Client Signature/Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sharon Gusmus, MA / LPC / CAS Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sharon Gusmus, MA, LPC, CAS Primary Therapist

MISSED APPOINTMENT/LATE CANCELLATIONS CHARGES

By signing below, I acknowledge that I am responsible for payment of charges by Sharon Gusmus or missing an appointment without at least 24-hour notice of cancellation. I acknowledge that the amount for which I am responsible in the event of a late-canceled or missed appointment is $50.00. I agree to pay this amount within 30 days of my late-canceled or missed appointment.

I understand that emergencies, bad weather, and illness do have the potential to interfere with our scheduled appointments. It is my policy to allow for one missed appointment or late cancellation without charge. After the first missed session, I must request the missed appointment/late cancellation fee.

 Client Signature Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sharon Gusmus, MA, LPC, CAS Primary Therapist

Colorado 720-404-4883

Client Name: Date of Birth: Nick name, or prefer to be called:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: M or F

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:

(Please circle or star your preferred phone number)

Home Phone:

Work Phone:

Cell/Other Phone:

 Email address:

Emergency Contact Name:

 Emergency Contact Phone Numbers:

Messages okay? Y or N

Ok to send email? Y or N

Ok to text? Y or N

Relationship Status Circle One: Married Divorced Widowed Single

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any current symptoms you are experiencing: 

\_\_\_\_Depression/Sadness \_\_\_\_Aggression/Violence \_\_\_\_Appetite Problems \_\_\_\_Sleep Disturbance \_\_\_\_Anger/Irritability \_\_\_\_Domestic Violence \_\_\_\_Relationship Conflicts \_\_\_\_Workplace Stress \_\_\_\_Communication/Trust Problems \_\_\_\_Chronic Medical Problems \_\_\_\_Binging/Purging/Anorexia

\_\_\_\_Isolation/Withdrawal \_\_\_\_Homicidal Thoughts \_\_\_\_Impulse Control Difficulty \_\_\_\_Difficulty Expressing Feelings \_\_\_\_Victim of Abuse \_\_\_\_Perpetrator of Abuse \_\_\_\_Addictive Behavior \_\_\_\_Alcohol/Substance Abuse \_\_\_\_Grief/Loss

\_\_\_\_Parenting Issues \_\_\_\_Sexual/Intimacy Issues

\_\_\_\_Suicidal Thoughts \_\_\_\_Self-Harm/Injury, Cutting, Etc. \_\_\_\_Anxiety, Panic, Worry, or Phobia \_\_\_\_Obsessions and/or Compulsions \_\_\_\_Low Self-Esteem/Confidence \_\_\_\_Problems Thinking/Concentrating \_\_\_\_Pronounced Mood Swings \_\_\_\_Stress/Feeling Overwhelmed \_\_\_\_Legal/Financial Problems \_\_\_\_Religious/Spiritual Issues \_\_\_\_Questioning of Sexual-Orientation/Gender

Indicate any current medications related to mental health/behavioral health (e.g., anti-depressants, anti-anxiety, sleep medications, Antabuse,etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and phone number of prescribing professional:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not on medication, is a referral for a medication evaluation needed? Yes or No Please list any current physical health concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list past and present tobacco, alcohol, and drug use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to see me?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., friend, name of doctor, name of website, etc.)

What concern brings you in? What goals do you hope to achieve through counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you participated in therapy before? If so, what was helpful and/or unhelpful about the experience? If not, what are your hopes and/or reservations about therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel our therapy together can be most helpful? Do you have thoughts or preferences about how you would like therapy to proceed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking the time to complete this information!



SAFETY ASSESSMENT

The following questions provide an initial assessment of potential safety concerns, which allows me to be more fully aware of and responsive to your therapeutic needs. Please feel free to ask me if you have any questions about how the information provided will be used in treatment.

* Recent thoughts of suicide
* Suicide attempt or suicidal actions in the past

Thoughts of being better off dead

*

Recently feeling hopeless about life or problems

Feeling no one cares

Struggling with alcohol or drug use

* Past hospitalization for mental health or drug/alcohol

Comments (optional):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_