Alisha L. Brosse, Ph.D.
Licensed Psychologist

MANDATORY DISCLOSURE STATEMENT, PATIENT CONSENT, & OFFICE POLICIES

Mental health care professionals are required by law to provide certain information to each patient (or, in the case of minors, to their legal guardian) during the initial contact, except in emergencies and court ordered situations. Additionally, it is important to me that I clearly communicate to you my general office policies at the beginning of our working relationship. Please read this document carefully, and do not hesitate to ask me clarifying questions or to express any concerns you have. Please initial and sign as requested throughout the document.

1. **Therapist name, credentials, and contact information:**
   Alisha L. Brosse, Ph.D., Licensed Psychologist (CO #2624; APIT* #6848)
   3020 Carbon Place, Suite 200, Boulder, Colorado 80301; phone: 720/252-0611

   *APIT = Authority to Practice Interjurisdictional Telepsychology. This authorization, granted by the PSYPACT Commission, allows me to provide telepsychology services to individuals located in states that participate in PSYPACT, an interstate compact designed to facilitate the practice of telepsychology across state boundaries. A current list of participating states is located at https://psypact.site-ym.com/page/psypactmap

2. **Concerns or complaints:** The practice of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations in Colorado's Department of Regulatory Agencies. If you have any concerns or complaints about mental health practitioners, you can contact the Board of Psychologist Examiners at: 1560 Broadway, Suite 1350, Denver, CO 80202; telephone 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 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 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 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 registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

3. **Confidentiality:** Any information that you provide during the course of evaluation or treatment is strictly confidential and legally protected "privileged communication." As such, I will not release information to any other person or agency without your consent and knowledge, except:

a. If I am directed by a judge in a court of law to reveal information, I am obligated to comply.
b. If I acquire knowledge or suspicion of current or future abuse of a child or dependent adult, I am legally required to report my knowledge or suspicion to the appropriate authorities.
c. If I believe that you are an *imminent* danger to yourself, I am required by law to take action to protect you. This may include psychiatric hospitalization and/or notifying the police or a loved one of your circumstances.
d. If I believe that you are a serious and imminent threat to another person, or to people at a particular location, I have a legal duty to warn that person and/or notify the police.
e. If you fail to pay your bill and decline to make arrangements with me to pay an outstanding balance, I reserve the right to employ a collection agency.
f. I may consult with other mental health professionals, without disclosing your identity, in order to provide you with the best possible care. Any individual with whom I consult will be a licensed professional who is bound by the same laws of confidentiality that bind me.
g. To protect public health, you or I may at some point become legally required to disclose that we have been in contact (for example, if either of us were to test positive for, or show signs of, COVID-19 infection). If I am legally compelled to disclose information, I will inform you and will only provide the minimum necessary information required by law (e.g., your name and the dates of our contact). I will not go into any details about the reason(s) for our contact.

Initial here to indicate your understanding of when I need to break confidentiality: _____

4. **Additional mandatory disclosure information:**
   a. You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. Please do not hesitate to ask me questions about your treatment as they arise.
   b. You may seek a second opinion from another therapist or may terminate therapy at any time.
   c. In a professional relationship, sexual intimacy is never appropriate and should be reported to the State Grievance Board.

5. **Fees & Payment:** My standard fee for a 50-minutes session is $200. Sessions of a different duration are pro-rated at $200 per 50 minutes. I offer a discounted fee of $180 per 50-minute session if (a) you do not require a formal invoice; and (b) you pay *at the time of session with cash* rather than check or credit card. These measures decrease my overhead costs and I am happy to pass the savings along to you. The exception to this discount is the first session, which is charged at a rate of $275 for a 75-minute session or $200 for a 50-minute session, regardless of form of payment.

   Payment is due at the end of each session unless other arrangements are made. Please notify me as soon as possible if, during the course of therapy, any problems arise regarding your ability to make timely payment.

   I accept cash, checks, and credit/debit cards. Please be aware that paying with a check or card compromises your confidentiality. For credit/debit card processing I use a service called Ivy Pay. I will provide Ivy Pay with your mobile phone number; they will text you a link to a secure website where you will be prompted to enter your credit card information and to authorize me to charge your card. Your card information will remain on file with Ivy Pay and I will submit charges as they accrue (e.g., after a completed or missed session). Please *initial here* to give me permission to provide your phone number to Ivy Pay: _____

The scheduling of an appointment involves the reservation of time specifically for us. To avoid being charged, please inform me of cancellations at least 24 hours in advance. **You will be charged $100 for late cancellations** (i.e., less than 24 hours' notice but prior to our appointment) **and the full session fee for missed appointments** (i.e., no alert prior to our session time).

6. **Insurance:** My services are rendered and billed to my patients, not to insurance companies. I am not on insurance panels and do not submit claims to insurance companies. If you have out-of-network benefits and would like to file for reimbursement, I will provide you with the information that you will need (e.g., diagnosis, billing code) in the form of a monthly invoice. It is your responsibility to determine whether, and how much, you will be reimbursed, and to file claims with your insurance company. You will pay at the time of our session, and there may be significant lag time before you receive any reimbursement. Also, filing insurance, flexible spending account, or health savings account claims compromises your confidentiality. Should it become necessary for me to communicate or file paperwork (e.g., a treatment plan) with your insurance company on your behalf, the following billing structure will be employed: the first 10 minutes will be free of charge; any additional time spent (e.g., on the phone; preparing or transmitting documents) will be charged at my standard rate on a prorated basis.

7. **Out-of-Session Communications:**
Please note that I do *not* provide 24-hour coverage. If you are experiencing a crisis and cannot wait for my reply, you can call the Colorado Crisis and Support Line (844/493-8255), the national Suicide and Crisis Lifeline (988), or 911; or, you can go to your local emergency room.

Phone: I make business calls from a cellular telephone. If you are not comfortable with the level of privacy offered on cellular devices, you may want to limit phone calls to non-sensitive matters. I check messages regularly throughout the day and it is important to me to return calls promptly. If I am **out of town** and unavailable for calls, the outgoing message on my phone will direct you to another qualified professional who has agreed to take calls for me.

Secure Messaging via Spruce Health: Spruce Health is a HIPAA-compliant communications platform with both phone and computer interfaces. When used on a smartphone, it mimics text messaging; on the computer, it feels like email. Certain types of files (pdf; jpeg; png) can be sent as attachments. I strongly encourage you to use the link I will share with you to install the Spruce Health application and automatically be connected to my practice. I*nitial here* if you would like me to send you an invitation to join me on Spruce: _____

If you send a standard text message to my phone number, it will appear in my Spruce Health inbox but it will not be end-to-end encrypted like it will be if you message me from your Spruce account. *Initial here* if I may send you SMS text messages for routine matters (e.g., scheduling) if, for example, you do not sign up for Spruce or temporarily don't have access to your Spruce account: _____

Electronic mail: **I generally do not use electronic mail** to communicate with – or about – patients. When email seems to be the best way for use to exchange information, Spruce Health provides a secure way to do the same. If there is a barrier to you using Spruce, and you would like me to have permission to use email to send you information (such as links for teletherapy

sessions; web resources; handouts), please *initial here* : _____ and indicate your preferred email address: _____

8. **Association with the Boulder Center for Cognitive & Behavioral Therapies, LLP (BCCBT):** I operate an independent private practice and am solely responsible for the clinical treatment that I provide you. BCCBT is a management services organization; it is not a group practice. I am a partner of BCCBT and I rent office space from BCCBT. However, in regards to our work together, I am not acting as a representative or employee of BCCBT. Neither BCCBT, nor any other partner or associate of BCCBT, is in any way responsible for my professional conduct in regards to your treatment.

By signing below you are indicating that you have read the preceding information, have had an opportunity to ask questions, and understand your rights as a therapy patient as well as my general office policies.

_____ _____

Patient Signature **Date**

_____

Patient Name (Printed)

PLEASE CONTINUE TO NEXT PAGE

INFORMED CONSENT FOR TELETHERAPY

Psychotherapy may be delivered by telephone or videoconferencing ("teletherapy"). Teletherapy is especially useful when either a therapist or client cannot participate in face-to-face sessions because of issues related to transportation, health and safety, and/or mobility. Additionally, teletherapy is a vital resource for people without equivalent local resources. However, there are some risks and limitations specific to teletherapy. This document is intended to outline potential risks as well as general guidelines for teletherapy. It is up to each client-therapist dyad to determine if the likely benefits of teletherapy outweigh the potential risks. Please read the following carefully so that you can provide fully informed consent for engaging in teletherapy services.

- **Teletherapy includes any single therapy session held by telephone or videoconferencing, even if most of our sessions are conducted in person.**
- We both should be in a quiet, private place with limited interruptions and distractions. This includes turning off "apps" and notifications on your electronic device(s).
- Ideally you will have the ability to take notes or to do exercises that involve closing your eyes or moving around (for example). Please do not drive during sessions.
- Please inform me if there is another person present during a session.
- Subtleties of communication, such as tone of voice and nonverbal cues, may be compromised when communicating via telephone or videoconferencing. This may result in an increased need to clarify what we heard from each other, which could at times slow progress.
- It can be challenging to share, exchange, or sign documents when we are in different locations. We will discuss technologies that are available to us both (e.g., fax; encrypted messaging platforms), and use the most secure mode of document exchange possible.
- When communicating via telephone or internet videoconferencing there is a non-zero risk that your privacy and confidentiality will in some way be compromised.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- We will use HIPAA-compliant programs whenever possible. I currently use a HIPAA-secure version of Zoom for videoconferencing, Spruce Health for HIPAA-secure messaging, and Signal for encrypted text messaging.
- Another potential risk of teletherapy is service interruptions or technical difficulties that compromise the quality or productivity of a session.
    - We may need to end a teletherapy session if our connection is poor.
    - For videoconferencing sessions, please have available a telephone so we can switch to this mode of communication if necessary.
    - Have your device(s) plugged in or a charger within reach to minimize the risk of session interruption.
- The same confidentiality protections, limits to confidentiality, and rules around medical records apply to a teletherapy session as they would to an in-person session.
- If you previously consented to having sessions recorded, that consent extends to teletherapy sessions. Please do not record sessions yourself without first discussing this with me.
- I should know where you are physically located during each teletherapy session. This will allow me to alert your emergency contact or emergency personnel in the unlikely event that a medical, psychiatric, or other emergency occurs during the session. Please tell me if you are somewhere other than the address I have on file for you.
- It is important for us to develop a safety plan, including identifying emergency contacts, local crisis services, and accessible hospitals in the event of a crisis situation.

- If at any time it is my professional opinion that teletherapy is insufficient to meet your needs I can stop offering teletherapy sessions and ask that we either meet in person or find other, more suitable services.
- All standard fees apply (including session, late cancel, and missed appointment fees). Your insurance company may reimburse differently for teletherapy versus in-person services.
- If technological difficulties on your end force us to cancel or shorten a session, you still will be responsible for paying for the scheduled time.
- You will be billed for international phone charges exceeding $5/call.

By signing below you are indicating that you have read the preceding information and have had an opportunity to ask questions. You understand that I am happy to try to help you locate in-person resources now or at any time in the course of our treatment should you decide that teletherapy is not sufficiently meeting your needs.

_____ _____

Patient Signature **Date**

_____

Printed Name (Printed)

PLEASE CONTINUE TO NEXT PAGE

POLICIES SPECIFIC TO MEETING IN PERSON

In response to public health orders during the COVID-19 pandemic, my practice transitioned to providing all services via telecommunications technology. This reduced the risk of spreading not only COVID-19, but all contagious illnesses, such as flu, stomach viruses, and the common cold. The following guidelines pertain to all in-person services moving forward.

1. **Do not come to the office** if you have symptoms of, or suspect you may be at risk of spreading, *any contagious illness*. For example, do not come to the office if:
   - you have had a **fever** in the previous 24 hours;
   - you have **vomited** in the previous 24 hours (except if this is clearly connected to a non-contagious illness, such as a migraine headache);
   - you are actively **coughing** or **sneezing**, OR you are suppressing these symptoms with medications (except if this is clearly connected to a non-contagious illness, such as allergies, COPD, or asthma); or
   - you know you had a **significant exposure** to someone who was ill and are still in the "at-risk" or "incubation" period for that illness.

2. I will follow the same guidelines. I reserve the right to convert any scheduled appointment from in person to teletherapy in order to protect our health and/or safety. This includes if I think I may be contagious with an illness, or if road conditions are (or are predicted to become) dangerous.

3. My **standard cancellation policy will remain in effect**. Please give 24 hour's advanced notice, or **request a teletherapy visit,** to avoid being charged for services you do not receive.

4. Our waiting room is small and does not allow for appropriate social distancing. Until you are instructed otherwise, please follow this procedure for in-person services:
   - Enter the suite at our scheduled meeting time (not early).
   - Follow posted signs regarding whether visitors to the office are required to wear a mask.
   - Help yourself to water or tea if desired.
   - If my door is open, come back to my office at (or after) our scheduled meeting time.

The decision about whether to engage in in-person versus remote services requires a careful balancing of the risks and benefits of each. The risks of, and guidelines for, in-person services can change at any time. I may at some point suspend the option of meeting together in person. Such a decision will be made in consultation with you, but I will make the final determination based on a careful weighing of the risks and applicable regulations.

By signing below you are indicating that you have read the preceding information. You agree to help me and my colleagues stay healthy by following these guidelines for in-person services.

_____ _____

Patient Signature **Date**

PLEASE CONTINUE TO NEXT PAGE

Emergency Contact

Please provide the name and telephone number(s) of a person I may contact if (a) there is a medical emergency during a therapy session or phone call; (b) I have reason to be acutely concerned for your safety; or, (c) you miss an appointment, fail to return phone calls, and I have reason to be concerned for your well-being. I will use this information very conservatively, always striving to protect confidentiality.

Name: _____ Relation: _____

Phone 1: _____ Phone 2: _____

By signing below you are giving me consent to call the above-named person under the conditions described above, understanding that I may need to identify myself as your therapist.

_____

Signature

NOTIFICATION OF NON-ACCEPTANCE OF MEDICARE/MEDICAID

By signing below you are acknowledging that you have been informed by Dr. Alisha Brosse, licensed psychologist, that she does NOT accept assignment for Medicare or Medicaid patients.

Individuals enrolled in *Medicaid* are required under their Medicaid contract to see only Medicaid providers. ***By signing below you are indicating that you are not enrolled in Medicaid***. Further, you understand that if you enroll in Medicaid at any time during your treatment, Dr. Brosse will be required to refer you to a Medicaid provider and your treatment with Dr. Brosse will not continue.

If you are insured by *Medicare*, you do hereby voluntarily choose to seek and/or continue treatment with Dr. Brosse by paying for such services out-of-pocket at her customary rates. You agree not to bill Medicare for such services. If you have secondary insurance, you understand that it will not pay for services that have not already been billed to Medicare, and thus will not cover services offered by Dr. Brosse. By signing below you also are acknowledging that you are aware that you could otherwise seek treatment from a clinical psychologist who does accept assignment on Medicare patients at a lower cost to you, but you choose not to do so.

_____ _____

Patient Signature **Date**

_____

Printed Name (Printed)