

**MANDATORY DISCLOSURE STATEMENT, PATIENT CONSENT, & OFFICE  
POLICIES: CBT FOR INSOMNIA GROUP**

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.

**1. Therapist name, credentials, and contact information:**

Alisha L. Brosse, Ph.D., Licensed Clinical Psychologist (CO #2624)  
3020 Carbon Place, Suite 200, Boulder, Colorado 80301; phone: 720/252-0611

- 2. Concerns or complaints:** The practice of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. If you have any concerns or complaints about mental health practitioners, you can contact the State Grievance Board at: 1560 Broadway, Suite 1340, Denver, CO 80202; telephone 303/894-7766. 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, 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.

I ask that you maintain the confidentiality of other group members. You may speak to others about *your* experiences in the group, but please do not speak about other group members. Furthermore, please be sensitive to issues of confidentiality if you see a fellow group member in another setting. Of course, in group therapy it is impossible for me to guarantee that other group members will maintain your confidentiality, but I will do everything I can to create a culture that encourages mutual respect and regard for your privacy.

**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 don't hesitate to ask me questions about your treatment as they arise. *You are enrolling in a 4-session group cognitive behavior therapy for insomnia. Each session will last 75 minutes. If you desire additional treatment at the completion of the group, we may work together in individual therapy or I may give you referrals to another qualified professional, depending on your preference and my availability.*
- 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:** The fee for this 4-session group is \$200, payable at or before the first group session. Because I am reserving a spot for you in this small group, the fee will remain the same even if you have to miss a session or decide to withdraw from the group before its completion. I accept cash, checks, and money orders (no credit cards). Please be aware that paying with a check compromises your confidentiality.

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 an invoice. It is your responsibility to determine whether, and how much, you will be reimbursed, and to file claims with your insurance company. Please remember that I will expect you to pay at the beginning of the group, and know that there may be significant lag time before you receive any reimbursement. Also know that filing insurance, flexible spending account, or health savings account claims compromises your confidentiality.

7. **Out-of-Session Communications:** I make most business calls from either a cellular or cordless telephone. If you are not comfortable with the level of privacy offered on cellular and cordless devices, please let me know and I will make every effort to contact you via a non-cordless land line. If this is not possible, you may limit phone calls to non-sensitive matters. I use my cellular phone with the same level of regard for privacy as I would a land line; that is, I will only answer in private and professional settings.

I check messages regularly throughout the day and it is important to me to return calls promptly. Please note that I do *not* guarantee 24-hour coverage and, during the day, I will not return calls when I am in session with other patients. If you cannot wait for my return call you can call the 24-hour crisis line operated by the Boulder County Mental Health Center (303/447-1665), or you can call 911 or go to your local emergency room.

If I am **out of town** and unavailable for calls, the outgoing message on my phone will instruct you to call another qualified professional who has agreed to take calls for me.

**I do not use electronic mail** to communicate with – or about – patients.

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 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.

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**Patient Signature**

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**Date**

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**Patient Name (Printed)**

### **PERMISSION TO CONSULT**

As indicated above (3f), I may consult with other mental health professionals for the express purpose of providing you with the best possible care, and I can do this without your written permission as long as I protect your identity. There are several professionals with whom I most frequently consult, and there are a couple of reasons that my ability to absolutely safeguard your identity may be compromised when I consult with these particular individuals. First, I share office space with these therapists and it is possible (though unlikely) that they will deduce whom I am talking about having observed you in the waiting room or hallway. Second, if you were referred to me by one of these therapists (either because you called him or her first, or because you called the BCCBT triage line while he or she was taking calls), he or she may recognize aspects of your case and may recall your name. For these reasons, and because it is so important to me to maintain the highest standards of confidentiality, I would like to ask your express permission to consult with Monika Hauser, Ph.D., and Bennett Leslie, Psy.D. I will make every effort to protect your identity and I will only seek consultation with the aim of providing you with the best possible care. Please sign here to indicate that I may consult with the above-referenced clinical psychologists. If you do not sign here, I reserve the right to consult with any licensed professional (including the above-named) as long as I am confident that I am not compromising your identity, as is permitted by law.

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**Patient Signature**

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**Date**

**NOTIFICATION OF NON-ACCEPTANCE OF MEDICARE/MEDICAID**

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

As an individual insured by Medicare and/or Medicaid, 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/Medicaid 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.

You also are acknowledging that you are aware that you could otherwise seek treatment from a clinical psychologist who does accept assignment on Medicare/Medicaid patients at a lower cost to you, but you choose not to do so.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name