

## **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.

**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:
- If I am directed by a judge in a court of law to reveal information, I am obligated to comply.
  - 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.
  - 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.
  - 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.
  - 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.
  - 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.

**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-minute session is \$170. Sessions of a different duration are pro-rated at \$170 per 50 minutes. I offer a discounted fee of \$150 per 50-minute session if (a) you do not require a formal invoice; and (b) you pay with cash rather than checks. 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 \$170 regardless of form of payment.

Payment is due at the end of each session unless other arrangements are made. I accept cash, checks, and money orders; I do **not** accept credit cards. Please notify me as soon as possible if, during the course of therapy, any problems arise regarding your ability to make timely payment. Please be aware that paying with a check compromises your confidentiality.

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 \$85 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 call/text 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. Please remember that I will expect you to pay at the time of our session, 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. 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 hourly rate on a prorated basis.
7. **Out-of-Session Communications:** I make most 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 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. *For less-sensitive communications*, such as scheduling issues, you are welcome to use *text messaging* if you prefer that over calling.

I check messages regularly throughout the day and it is important to me to return calls promptly. Please note that I do *not* provide 24-hour coverage. If you cannot wait for my return call you can

call the 24-hour Colorado Crisis and Support Line (844/493-8255), 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 direct you to another qualified professional who has agreed to take calls for me.

**I generally do not use electronic mail** to communicate with – or about – patients. On occasion email may be the best way for me to send you information (e.g., a handout, links to websites). I will only do this with your express permission, and your understanding that email is not secure. Please do not use email to communicate sensitive information to me. I also prefer that you not use email for scheduling issues, as I tend to lose track of these.

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)**

### **Emergency Contact**

Please provide the name and telephone number(s) of a person I may contact if (a) there is a medical emergency while you are at my office; (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.

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**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 the 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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