

Colorado Mandatory Disclosure of Information

1. The practice of both licensed and unlicensed persons and school psychologists in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The address and phone number for the grievance board is:
Mental Health Licensing Section of the Division of Registrations
1560 Broadway St.
Denver, CO 80202 303-894-7800

The address and phone for Colorado Department of Human Services is :
CDHS
3824 W. Princeton Cir.
Denver, Co 80236 303-866-7400.

2. As a client, you are entitled to receive information about methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.
3. Your therapist is: Dianna Sandoval and her credentials are LPC, LAC.
Licensed Clinical Social Worker, Licensed Marriage and Family Therapist and Licensed **Professional Counselor must have a master's degree in their profession and have two years of post-master's supervision.**
Certified Addiction Counselor II (CACII) must complete additional required training hours and 2,000 hours of supervised experience.
Certified Addiction Counselor III (CACIII) must have a bachelor's degree in behavioral health, complete additional training hours and 2,000 hours of supervised experience.
Licensed Addiction Counselor must meet the requirements of the CACIII and have passed the Master Addiction Counselor (MAC) exam.
4. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the HIPAA Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal Law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: <http://www.dora.state.co.us/mental-health/Statute/pdf>. Clinical information will be shared among staff at Tandem Wellness Center.
5. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
6. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

7. Substance Abuse/Mental Health treatment is not an exact science therefore no guarantees can be made regarding the process or outcome of these services.
8. At least 24-hour notice is requested a 4 hour notice is required in the event of a canceled appointment. If cancellation is made after that period, or if the client misses an appointment without notification, the client will be charged \$50 to be paid by the next session as a condition of returning to treatment.
9. If you are in treatment for Substance Abuse, Tandem Wellness Center may conduct random drug and/or alcohol testing at our discretion.
10. Insurance will be billed, if applicable, however the client is responsible for payment of fees whether or not insurance reimburses for services rendered. For self-pay clients the fee is \$100 per individual session, and \$100 for couples or family session. There is no charge for telephone consultations dealing with insurance matters, appointment confirmations, cancellations, or scheduling. Extra therapeutic services such as telephone consultations of a therapeutic nature, report or letter writing, and collateral contacts will require a separate fee.
11. If you are experiencing an emergency or need urgent care, please call 911, or go to the nearest hospital facility. For non-critical situations, you can reach our staff at 303-359-1352. We will respond within 24 hours.
12. Treatment requires active participation by the client, as well as participation by family members when applicable.

The client's signature evidences his/her approval of all terms, conditions, and policies set forth herein.

My signature further affirms that I understand and agree with the goals and plan for treatment. I give consent for evaluation and treatment to be provided for myself/my child by Tandem Wellness Center, LLC.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Date _____ Print Client Name _____

Client's or Responsible Party's
Signature _____

If signed by Responsible Party, please state relationship to client and authority to consent:

Therapist _____