



Consent for Treatment and Center Policies

Patient name(s) _____

All mental health care professionals are required by law to provide the following information to each patient (or in the case of a minor to their legal guardian) during the initial contact. We also want to communicate to you some of our policies regarding out-of-session communication.

1. Contact information: Robert D. Sutherland Center
Muenzinger Building, University of Colorado at Boulder
Box 345 UCB
Boulder, CO 80309-0345
Business phone: 303/492-5680
2. Credentials: Sutherland Center psychotherapists are either licensed clinical psychologists holding a doctoral degree in clinical psychology, or are graduate students working toward their doctoral degree in clinical psychology. Graduate student therapists are supervised by a doctoral level, licensed clinical psychologist (Alisha Brosse, Ph.D., CO License #2624). As to the regulatory requirements applicable to mental health professionals: a Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. 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 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. 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. If you have any concerns or complaints about a mental health practitioner, the Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202; 303/894-7800.
4. You are entitled to receive information from your therapist(s) about the methods of treatment, the techniques used, the duration of treatment (if known) and fee and billing practices. If you qualify for services at the Sutherland Center, information regarding fees, billing, and the duration of services will be provided in a separate document (“Financial Agreement” or “Treatment Program: Your Individual Plan & Treatment Contract”).
5. You can seek a second opinion from another therapist or terminate therapy at any time.

6. 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.
7. Generally speaking, the information provided by and to you during the course of evaluation or treatment is legally confidential and cannot be released without your consent. If a legal exception arises during therapy we will inform you accordingly if it is feasible to do so. Examples of when we will share your information include:
 - a. We must report to Social Services any knowledge or suspicion of abuse against a child or dependent adult.
 - b. We are required by law to take action to protect you if you become an imminent danger to yourself. Action in this situation may include psychiatric hospitalization and/or notifying a loved one of your circumstances.
 - c. By law, if you are a serious and imminent threat to another person, or threaten violence at a specific location, we have a duty to warn that person and/or notify the police or other appropriate authorities.
 - d. If we are directed by a judge in a court of law to reveal information, we must comply.
 - e. Different members of your Sutherland Center treatment team (for example, individual therapist and therapy group leaders) will talk with each other to coordinate your care. In addition, Sutherland Center therapists meet weekly for group supervision; therefore, therapists other than your own may hear about your treatment. We also may consult with other (non-Sutherland) clinicians (without revealing identifying information) in order to provide you with the best possible care. All of the above-mentioned clinicians are bound by laws of confidentiality.
8. Out-of-session Communication:
 - a. The Sutherland Center does not offer a 24-hour on-call service. In the event of a clinical emergency, please refer to the document “Out of Session Communication and Clinical Emergencies.”
 - b. It is the policy of the Sutherland Center not to use electronic mail (email) to communicate with or about clients. Occasionally you and your therapist may agree that email is the best way for your therapist to provide you with an electronic copy of a handout or similar resource; this will only be done with your permission and your understanding about the limits of confidentiality. Please do not subsequently use your therapist’s email address as a way of contacting him or her.

Signing below indicates that you have read the preceding information, you have had an opportunity to ask questions, and you understand your rights as a patient or as the patient’s responsible party.

Signature of client or responsible party Date

Signature of client or responsible party Date



CONSENT TO TAPE &
CONSENT FOR LIVE OBSERVATION

Name of Client(s) (please print)

Therapists at the Sutherland Center consult with one another to continually improve the quality of the services they provide. In addition, some therapists are preparing for their doctoral degree in Clinical Psychology at the University of Colorado, under the supervision of an experienced psychologist (Ph.D.) or psychiatrist (M.D.). To further the training of our therapists, we ask your permission to record and/or observe treatment sessions. Audio and video files will be used only for the purposes of professional consultation or training, and shared only with mental health providers who are bound to maintain confidentiality. Live observation behind a one-way mirror is primarily used for supervision of, and training in, group therapy, and both supervisors and trainees may observe group from time-to-time. *Consent for live observation is required for participation in the Center's ABC's and XYZ's therapy groups.*

I understand the conditions described above and give permission for recording clinical sessions.

- Yes, I give permission for audio/visual recording clinical sessions.
- No, I do not give permission for audio/visual recording clinical sessions.

I understand the conditions described above and give permission for live observation of therapy sessions.

- Yes, I give permission for live observation of therapy sessions.
- No, I do not give permission for live observation of therapy sessions.

Signature of client or legal guardian

Date

Signature of client or legal guardian

Date

Signature of client or legal guardian

Date

Signature of client or legal guardian

Date



FINANCIAL STATEMENT

Client Name(s): _____

Date: ____ / ____ / ____

The following financial information will be used to determine if you qualify for services at the Sutherland Center, and to determine your fee for services.

HOUSEHOLD INCOME:

Your Employment	\$ _____
Spouse's/Partner's Employment	\$ _____
Child Support/Alimony	\$ _____
Unemployment Compensation	\$ _____
Disability/Social Security	\$ _____
Money from Relatives	\$ _____
Other	\$ _____
TOTAL	\$ _____ (Check if __ monthly or __ annual)

Number of individuals supported by this income: ____

HEALTH INSURANCE:

Do you have health insurance? ____ No ____ Yes

If YES:

What plan (e.g., Anthem; Medicaid; CICP)? _____

Does your plan include mental health benefits? ____ No ____ Yes

What is your annual deductible? \$_____ Have you met the deductible this year? _____

What is your co-pay per visit? \$_____

Please list any extenuating circumstances that make it difficult for you to afford treatment even if you have income and/or insurance (e.g., money spent on medications or medical care, large debts).

I (We) certify that all information provided above is accurate.

 Signature of client or legal guardian

 Date

 Signature of client or legal guardian

 Date