



denver integrative assessment

DISCLOSURE STATEMENT & POLICIES

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO

1. Denver Integrative Assessment (“DIA”) is located at 1777 S. Harrison Street Suite 800, Denver, CO 80210, 303-300-6564. The mental health professional located at DIA is Katherine K. Bellon, Ph.D. Dr. Bellon received her Ph.D. in Clinical Psychology from the Fielding Graduate University in January 2010. She completed a portion of her post-doctoral work as a research/clinical psychologist in the Mental Illness Research, Education, and Clinical Centers (MIRECC) at the Denver VA Hospital, and the rest of her post-doctoral work was completed in private practice training in therapeutic assessment and psychoeducational evaluations. Dr. Bellon is licensed as a psychologist in the state of Colorado (#3782). She is a member of the American Psychological Association, the APA Division of School Psychology, the Colorado Psychological Association, the Colorado Assessment Society, the Society for Personality Assessment, and Children and Adults with Attention-Deficit/Hyperactivity Disorder.

2. Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for his or her minor child/ren, must sign this disclosure statement on behalf of his or her minor child under the age of fifteen (15) years old. This disclosure statement contains the policies and procedures of DIA and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

3. The Colorado Department of Regulatory Agencies (“DORA”), Division of Professions and Occupations (“DOPO”) has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Licensed Psychologist Examiners regulates Licensed Psychologists, and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through DIA’s internal process.

4. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your evaluator.

5. Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications). All levels of regulation require passing a jurisprudence take-home examination.

Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. Certified Addiction Counselor III (CAC III) must have a bachelor’s degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselor must have a clinical master’s degree and meet the CAC III requirements. Licensed Social Worker must hold a master’s degree in social work. 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. Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in his or her profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. Registered Psychotherapist is a psychotherapist listed in Colorado's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. Registered psychotherapists are required to take the jurisprudence exam.

CLIENT RIGHTS AND IMPORTANT INFORMATION

As a client you are entitled to receive information from me about my methods of assessment, the techniques I use, the duration of your assessment, if I can determine it, and my fee structure. Please ask if you would like to receive this information.

Fees:

1. My fee structure, services, and fee policy are outlined as follows:

- a. \$200.00 per hour
- b. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.
- c. I **am not** a Medicaid provider. If you have Medicaid coverage that includes mental health services, I **am not** able to offer mental health services to you.
- d. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is \$300.00 per hour.

Restrictions on Uses:

2. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however DIA is not required to agree to a restriction request. Please review DIA's Notice of Privacy Policies for more information.

Second Opinion and Termination:

3. You are entitled to seek a second opinion from another evaluator or terminate assessment at any time.

Sexual Intimacy:

4. In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Licensed Psychologist Examiners.

Confidentiality:

5. Generally speaking, the information provided by and to a client during assessment sessions is legally confidential if the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Certified and Licensed Addiction Counselor, or a Registered Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client’s consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

6. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out DIA’s Consent for Communication of Protected Health Information by Unsecure Transmissions.

Extraordinary Events:

7. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter “extraordinary event,”) the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Alexandra McDermott, PsyD
ADDRESS: 600 South Cherry Street, Suite 230
Denver, CO 80246
TEL: (720) 485-4194
CREDENTIALS: Clinical Psychologist, CO License #4285

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for assessment services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Electronic Records:

9. DIA may keep and store client information electronically on DIA’s laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, DIA may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers

and/or mobile devices from unauthorized access. DIA may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

The email service provider DIA uses is Gmail. DIA may maintain the security of the electronically stored information through encryption and passwords. In addition, to maintain security of the electronically stored information DIA has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with the email service provider. Because of this Agreement, the email service provider is obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The email service provider employs various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the email service provider's workforce members, to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures DIA employs, please ask.

Discounted Services

10. You may have an option of receiving discounted services from students or interns. If this option is available and you would like this as an option, I will discuss the rate of services, provide a written copy, and the intern's separate disclosure statement as well.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that DIA may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with DIA's Consent for Communication of Protected Health Information by Unsecure Transmissions.
2. I understand that if I initiate communication via electronic means that I have not specifically consented to in DIA's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my evaluator may communicate with me via this method.
3. I understand that there may be times when my evaluator may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in assessment. My confidentiality is still protected during consultation by my evaluator and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my evaluator permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my evaluator.
4. I understand that my evaluator does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that DIA has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" DIA's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on DIA's page/wall as well. I understand that any comments I post regarding therapeutic work between my evaluator and me will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment

and/or question that I will contact my evaluator through the mode to which I consented and **not** through social media.

5. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my evaluator and address those questions.

6. I understand my evaluator provides non-emergency assessment services **by scheduled appointment only** and does not provide therapy services. If I am having a mental health emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due.** I understand that if I leave a voicemail for my evaluator on the phone number provided, my evaluator will return my call by the end of the next business day, excluding holidays and weekends.

7. If my evaluator believes my evaluation requirements are above his or her level of competence, or outside of his or her scope of practice, my evaluator is legally required to refer, terminate, or consult.

8. I understand that DIA does not work directly with insurance providers but that I may seek reimbursement from my insurance company myself. I understand that I am legally responsible for payment for my assessment services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my evaluator, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my evaluator to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my assessment funding source regarding payment. I understand that my insurance company may request information from my evaluator about the assessment services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my evaluator's entire client file. I understand that once my insurance company receives the information I or my evaluator has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my evaluator a copy of any report DIA submits to my insurance company on my behalf. Failure to pay will be a cause for termination of assessment services.

9. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

10. I understand that if I have any questions about my evaluator's methods, techniques, or duration of assessment, fee structure, or would like additional information, I may ask at any time during the assessment process. By signing this disclosure statement, I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in assessment when deemed necessary by myself or my evaluator. I agree that these parties will have to sign a separate Consent for Third-Party Participation Agreement or may have to sign a separate disclosure statement in order to participate in assessment.

11. I understand that should I choose to discontinue assessment for more than sixty (60) days by not communicating with DIA or my evaluator, my treatment will be considered "terminated." I may be able to resume assessment after the sixty (60) day period by discussing my decision to resume assessment services with DIA. Ability to resume assessment after sixty (60) days will depend upon my evaluator's availability and will be within his or her sole discretion. This disclosure statement will remain in effect should I resume assessment if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing assessment" means that I have

not had a session with my evaluator for at least sixty (60) days, unless otherwise agreed to in writing.

12. There is no guarantee that participation in an evaluation will yield positive or intended results. Although every effort will be made to provide a positive experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

13. Because of the nature of assessment and therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the assessment process the therapeutic relationship must remain solely that of evaluator and client. This means that my evaluator cannot be my friend, cannot have any type of business relationship with me other than the therapeutic relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for testing); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of evaluator to his or her relatives, friends, the relatives of friends, people known socially, or business contacts.

14. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my evaluator has a right to charge my credit card on file, or my account, for the full amount of my session.

15. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and assessment services here at DIA or that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15), for whom I am requesting assessment services here at DIA.

16. I understand that if I am consenting to assessment services for my minor child/ren that my evaluator will request that I produce the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child. Further, I understand and agree to keep my evaluator informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my evaluator from providing assessment to my minor child/ren. I understand that it is beyond the scope of my evaluator's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

17. By signing this form, I affirm that I am fully informed of the assessment services I am requesting and that DIA is providing, and grant my consent to receive such assessment services.

My signature below affirms that the preceding information has been provided to me in writing by my primary evaluator, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my evaluator.

Client Name/Signature

DATE

Parent/Legal Guardian Signature (Please specify Relationship to Client)

DATE

Parent/Legal Guardian Signature (Please specify Relationship to Client)

DATE

Katherine K. Bellon, Ph.D.

DATE