

BARRY ERDMAN, MSW, ACSW, LCSW, DCSW

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PSYCHOTHERAPY DISCLOSURE AGREEMENT

The following information is intended to explain and simplify our arrangement for working together. It also includes disclosure information required by Colorado state law. Please sign, date and return it to me before our second session. I'll give you a copy to keep. If you have any questions, Please feel free to ask me about them when we next meet.

Beginning Therapy: It is essential to choose a therapist whom you can trust is right for you. For this reason, you are invited to interview me and ask about my clinical training, credentials, professional experience, therapeutic orientation, methods and techniques. I am interested in discussing and setting appropriate goals for our working together, and the expected duration of our counseling in order to meet your goals. You are also welcome to get a second opinion from another therapist at any time. If you are undecided about working with me initially, you are welcome to meet with me for one session at no cost to you. If during or after that initial session you choose to continue working with me, the initial session will be billed as our first session.

Fees/Payment: \$125.00/hour for individual, couples or family therapy. (\$75.00/hour group therapy).

Cash, check or credit card payments are accepted in office and due in full at the time of your scheduled appointment. Online payments in advance can be made using Paypal. A link to Paypal is provided on my web site. Therapeutic phone calls longer than ten minutes, extended consultations and other auxiliary services requested will be prorated accordingly. Additional traveling fees may be charged for out of office visits. A late payment fee of 2% interest compounded monthly will be added to balances remaining unpaid after 30 days. You are responsible for any additional returned check or credit card fees. Collection procedures may be initiated after a 60-day period where no attempt or agreement is made to pay off balance otherwise. Any exceptions to the policy above must be discussed and agreed to beforehand.

Cancellations/Missed Appointments: 24-hour notice is required to cancel or reschedule appointments without penalty. Exceptions made only for emergency circumstances (ex.: Hazardous driving conditions, severe or contagious illness, etc.). ***Missed appointments are charged at the full session rate. Appointments cancelled or rescheduled within 24 hours are billed at \$75.00.***

Billing/Insurance: *You are responsible for payment in full, regardless of your insurance coverage or claim status.* A billing statement will be made available to you and will contain all pertinent information required by your insurance company for reimbursement. Please file your own insurance claim by attaching and mailing my statement with your insurance claim form. Co-payments are accepted only after insurance claims have been processed or benefits verified. You must sign the "assignments of benefits to provider" section if you arrange to only pay the co-payment. While I may be listed as a preferred provider for your network, it's recommended that you call to verify your coverage and/or request pre-authorization to ensure receiving benefits. Billing for your diagnosis or treatment may not necessarily be accepted by your insurance plan. Some plans require special billing attention and handling. Please check with me if you have questions. I'll do my best to assist you, where ever possible. By signing this agreement it is understood that you are giving me permission to provide your insurance company with necessary information for billing and payment purposes.

Confidentiality: Generally speaking, the information provided by and to a client during your therapy sessions is legally confidential. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed by you to a licensed social worker is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates. There are exceptions to the general rule of legal confidentiality. Some of these exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). Exceptions include cases of imminent danger to self or others, or child abuse. If practicable, I will identify exceptions to you as the situations arise during therapy.

Communication: My confidential phone voice mail will take your message if I am with another client or otherwise unavailable. I generally check messages throughout the day, in the evening and during the weekends, but I may not be able to return your call immediately. ***I do not provide on call crisis intervention.*** When I am out of town, my phone message will direct you to a colleague for clinical consultation during my absence. You may also e-mail me for brief communications or scheduling inquiries. however, ***communicating by e-mail is never secure and may breach confidentiality mandates.*** I usually read my e-mail on a daily basis, but will respond to phone messages more reliably.

Termination of Therapy: You may discontinue therapy at any time. If you decide to change our plan for meeting, please discuss this with me before quitting. I also reserve the right to discontinue meeting with you if you do not keep agreements with me, including your financial responsibilities.

Regulation: The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of psychotherapists, including licensed social workers. The agency within the Department that has responsibility specifically for psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7766. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.

Modifications:

I have read the above information and understand my rights as a client. I agree to the terms as stated above. I understand that I may be responsible for any added expenses including court or attorney's fees if I do not follow the terms of this contract.

Client/Guardian Signature

Date

Client's Name (Print): _____

Relationship to Client: _____