

DISCLOSURE STATEMENT AND CLIENT'S RIGHTS

I, Dianna North, hold a Masters degree in Holistic Counseling from Salve Regina University in Rhode Island (1993). I am also certified through the National Association of Rubenfeld Synergists in the Rubenfeld Synergy Method® after completing their 1500+ hour training (1991). In addition, I hold a Bachelor's of Science degree in education from the State University of New York in Buffalo (1965). Because of my training and clinical experience, my theoretical orientation is a Holistic, Body-Mind approach. (see Therapeutic Orientation form for further information)

I am neither a medical doctor, nor a psychologist, and am unlicensed in the State of Colorado. My services are not intended to substitute for medical treatment, and nothing said or done by me should be misconstrued as such. I advise you to seek the medical advice of a licensed physician and/or psychiatrist should you have a condition that warrants medical attention.

Due to my position as a trained counselor and Rubenfeld Synergist, I am bound by the ethical and legal standards of all persons practicing psychotherapy, counseling, and Rubenfeld Synergy. During our work together, you will be supported to make constructive changes that are in alignment with the goals you formed during the intake process. You will have the opportunity to explore options, solve problems, clarify values, learn new skills, and make productive changes.

YOUR CLIENT RIGHTS AND IMPORTANT INFORMATION:

For your information, The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, and unlicensed individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7766.

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. This information is contained in your packet. Please ask if you would like any additional information.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. 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.

d. Generally speaking, the information provided by and to a client during therapy

sessions is legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist 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. 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 do not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.
- The right to confidentiality is also limited:
 - When there is reasonable cause to know or suspect a child and is being neglected or abused.
 - When a client appears to be at serious risk of harming self or others.
 - During case review in clinical supervision, or a court-ordered proceeding.
 - [See Colorado Statutes (C.R.S. 12-43-218) for further information]
- There may be other exceptions that I will identify to you as the situations arise during therapy

I understand that there may be times when my psychotherapist may need to consult with another professional. I will be given an Authorization for Release of Information form to sign at that time. Signing that form will give my psychotherapist permission to consult as needed to provide professional services to me as a client.

I understand my psychotherapist provides non-emergency psychotherapeutic services by scheduled appointment. If she believes my psychotherapeutic issues are above her level of competence, or outside of her scope of practice, she is legally required to refer, terminate, or consult. If, for any reason, I am unable to contact my psychotherapist by telephone, (303-499-2567), and I am having a true emergency, I will call 911 or check myself into the nearest hospital emergency room.

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 psychotherapy if deemed necessary by myself or my psychotherapist. I understand that should I have questions or would like additional information, I am free to ask at any time during the psychotherapy process.

I understand that I am legally responsible for payment for my psychotherapy services. I have read the preceding information, and I understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. I understand that any recommendations which I may receive are intended as personal guidance and education only. I am aware that I am free to act upon or disregard any and all suggestions as I choose, and that I am free to terminate this relationship at my discretion. In accordance with HIPAA: This consent to treatment expires after twelve months. This consent form can be revoked at any time.

During our work together, you will be supported to make constructive changes that are in alignment with the goals you formed during the intake process. You will have the opportunity to explore options, solve problems, clarify values, learn new skills, and make productive changes.

If you have any questions or would like additional information, you are always free to ask.

Client Signature

Date

Counselor

Date

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