



Averill Hovey, MA, MA, LPC, ATR-BC, EMDR
970-235-0075
averillhoveylpc@gmail.com
www.averillhoveylpc.com

Disclosure Statement and Informed Consent

The following describes how mental health information about you may be used, disclosed, and how to gain access to this information. Please review the following information carefully.

Contact Information:

Averill Hovey, LPC, ATR-BC, EMDR-Certified
102 E Cleveland Street, Suite 201
(970) 235-0075; averillhoveylpc@gmail.com
www.averillhoveylpc.com

Degrees:

MA in Transpersonal Counseling Psychology, Naropa University; MA in Educational Psychology; University of Colorado, Denver; BA in Mass Communications, University of Denver

Credentials and Professional Organization Memberships:

Licensed Professional Counselor, #12756, State of Colorado
Board Certified Art Therapist, #17-045, Art Therapy Credentials Board
EMDR Certified- trained by Julie Greene, MA, LPC, EMDR; EMDRIA approved trainer
Member of the American Art Therapy Association (AATA)
Member of the Art Therapy Credentials Board (ATBC)
Member of the American Counseling Association (ACA)
Member of EMDRIA (the Eye Movement Desensitization and Reprocessing International Association)

Regulation of the Practice of Psychotherapy:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, **licensed professional counselors**, licensed marriage and family therapists, certified and licensed 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, CO 80202
(303) 894-7766
DORA_MentalHealthBoard@state.co.us

The 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.

As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a **Licensed Professional Counselor** must hold a master's degree in their profession and have two years post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral 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 III must have a bachelor's 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 master's 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.

Client Rights, Policies, and Important Information:

- a. You are entitled to receive information about the methods of psychotherapy, the techniques used, the duration of the therapy (if known), and the fee structure. Please ask at any time and review my financial and procedural policies.
- b. You may seek a second opinion from another therapist or terminate therapy at any time.
- c. 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. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section at (303) 894-7766 or DORA_MentalHealthBoard@state.co.us .

d. Generally speaking, the information provided by and to a client during therapy is legally confidential if the therapist is a licensed psychologist, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, certified or licensed addiction counselor, psychologist candidate, registered psychotherapist, licensed professional counselor candidate, marriage and family therapist candidate, or counseling intern. If the information is legally confidential, the therapist cannot be forced to disclose 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.

e. When working with a minor, a summary of the child's progress will be provided to the parent(s) or guardian(s) upon request, but information provided during therapy by the minor is also protected by law. If the minor is fifteen (15) years of age or older, it is within your primary therapist's discretion to advise the parents of the services given to or needed by the minor.

f. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however, I am not required to agree to a restriction request. Please review The Notice of Privacy Practices.

g. There are exceptions to this confidentiality, some of which are listed in The Notice of Privacy Practices you were provided. The following are exceptions to the legal rule of confidentiality:

- i. You sign a release of information form giving permission for the therapist to provide specified information about your treatment to a particular individual or agency.
- ii. The therapist reasonably suspects or has proof of child abuse and/or neglect.
- iii. The therapist reasonably suspects or has proof of abuse, neglect, and/or exploitation of elderly or disabled individuals.
- iv. You are in imminent danger of harming yourself and/or others, including those identifiable by their association with a specific location or entity. In this situation, your primary therapist is required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened.
- v. Therapist testimony is subpoenaed in criminal court cases and orders to violate privilege by judges in child-custody, divorce, and other court cases.
- vi. You file a suit or grievance against the therapist.
- vii. The therapist is being reviewed by the Mental Health Section of the Division of Registrations.
- viii. These provisions do not apply in delinquency or criminal proceedings except as provided in C.R.S. 13-90-107.

There may be additional exceptions as provided by HIPAA regulations and other federal and/or Colorado laws and, regulations such as those listed in C.R.S 12-43-218 that may apply. Your primary therapist will identify these situations, if practicable, as they may arise during treatment or during the professional relationship.

h. There may be times when I may need to consult with a colleague or another professional such as an attorney or supervisor, about issues raised by you in therapy. Your confidentiality is still protected during consultation by me and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives your primary therapist permission to consult as needed to provide professional services to you as a client. You will need to sign a separate Authorization for Release of Information for any discussion or disclosure of your protected health information to another professional besides an attorney retained by me.

i. In therapy where a family is the “client,” I hold a “no secrets” policy. All members of the family are treated equally and secrets are not kept that require differential or discriminatory treatment of family members. This means that there may be times when individual sessions would be beneficial to the therapeutic process in the course of family counseling. If I meet with one or multiple members of the family in individual sessions, the contents of those meetings will likely be shared with the non-attending members at the next group/family session. The information shared in individual sessions is not confidential from the other participating members. Should you reveal information that may be harmful to other participating members and you refuse to disclose the information, therapy services, among other things, may be terminated. I may choose to disclose information revealed in the individual sessions if I, in my sole discretion, determine that the information must be disclosed for therapy to be effective. If appropriate, I will give you the opportunity to disclose the information first. However, I will not lie or refuse to answer any question posed by the other family members. Should you feel it is necessary to disclose something to me and keep that information confidential, I can refer you to another therapist who can treat you individually. Please be aware that information you choose to share with me that is particularly pertinent to all participating members of the family may come out in counseling. This pertains to all face-to-face, written, and phone conversations and messages. I cannot be subpoenaed to testify or produce records without consent and authorization from all participating members of the family.

j. I provide non-emergency psycho-therapeutic services by scheduled appointment only. If I believe your psychotherapeutic issues are above my level of competence or outside of my scope of practice, I am legally required to refer, terminate, or consult. If, for any reason, you are unable to contact me by telephone, and you are having a true physical or mental health emergency, please dial 911, go to your nearest emergency room, or call Colorado’s Crisis Hotline (844) 493-8255. If you must seek after hours treatment from any counseling agency, center, emergency room, hospital or similar facility, you are solely responsible for any fees due. I do not provide after hours service without an appointment.

k. In the case that your I become disabled, die, or am away on an extended leave of absence (hereinafter “extraordinary event,”) another therapist (“the Mental Health Professional Designee”) will have access to your 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 this and you can discuss possible alternatives with me at this time.

The purpose of the Mental Health 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 therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

l. Paper patient records are kept in locked file cabinets at my office. Electronic records are stored on my computer. Information is backed-up regularly through additional hard drives and on “the cloud.”

m. 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 the communications. There is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Emails and texts, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Faxes can easily be sent erroneously to the wrong address. Please limit communication by text or email to administrative purposes only and do not use them as an avenue for therapy. NEVER use email or text for emergencies. Please note that the business number for me is a Google Voice phone number.

n. Regarding and acknowledging social media, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Adding clients as friends or contacts can compromise your confidentiality and respective privacy. Please feel free to discuss your questions with me at this time.

o. I regard client artwork as a form of protected information and the property of the client. In some practice settings client artwork, or representations of artworks, may be considered a part of the clinical record retained by the therapist and/or agency for a reasonable amount of time consistent with state regulations and sound clinical practice. Client artwork may be released to the client during the course of therapy and upon its termination, in accordance with therapeutic objectives and therapeutic benefit.

i. The client is notified in instances when the I retain copies, photographic reproductions or digital images of the artwork in the client file as part of the clinical record.

ii. If termination occurs as a result of the death of the client, the original artwork is released to relatives if (a) the client signed a consent specifying to whom and under what circumstances the artwork should be released; (b) the client is a minor or under guardianship and I determine that the child's artwork does not violate the confidentiality the child entrusted to me; (c) I received and

documented clear verbal indications from the client that the client wanted part or all of the artwork released to family members; or (d) mandated by a court of law.

p. I obtain written informed consent from clients or, when applicable, legal guardians, in order to keep client artwork, copies, slides, or photographs of artwork, for educational, research, or assessment purposes. I do not make or permit any public use or reproduction of client art therapy sessions, including dialogue and artwork, without written consent of the clients. I obtain written informed consent from clients or legal guardians (if applicable) before photographing clients' artwork or video-taping, audio recording, otherwise duplicating, or permitting third party observation of art therapy sessions. I obtain written, informed consent from clients or legal guardians (if applicable) before using clinical materials and client artwork in any teaching, writing, and public presentations. Reasonable steps are taken to protect client identity and to disguise any part of the artwork or videotape that reveals client identity.(See Art Therapy Release Form.)

q. All client artwork will be stored digitally while the client is receiving art therapy services and the duration of retention for the actual artwork, photographs or digital images is in accordance with the Colorado Department of Regulatory Agencies storage of clinical notes (7 years.)

r. Any person concerned about a possible violation of the Art Therapy Credentials Board (ATCB) Standards of Ethics and Conduct, or other ATCB standard, policy or procedure, may initiate a written grievance, in as much detail and specificity as possible, including identifying the person(s) alleged to be involved and the facts concerning the alleged conduct. The written grievance should be accompanied by all available documentation. The grievance should be addressed to the Executive Director. A person initiating a grievance shall be referred to as the complainant:

Executive Director
ATCB
7 Terrace Way
Greensboro, NC 27403-3660
Toll Free: 877.213.2822
Phone: 336.482.2858
Fax: 336.482.2852
Email: atcbinfo@atcb.org

s. This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to your privacy will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Consistent with HIPAA guidelines authorizations for release and consent for treatment will be automatically revoked one year after signing date. You received my Notice of Privacy Policies and Practices, and acknowledge receipt of the policy.

If you have questions or would like more information, please ask at any time.

I have read the preceding information and it has also been provided verbally if I am unable to read or have no written language. I understand my rights as a client or parent of a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal right to consent to treatment for any minor child or children for whom I am requesting psychotherapy services.

Client('s) Name(s):

Client or Parent/Guardian Signature:

Date: _____

Date: _____

Therapist Signature:

Date: _____