One Day at a Time Counseling

April Cordova-Williams, LPC, NCC

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PROFESSIONAL DISCLOSURE STATEMENT

ABOUT MY THERAPIST:

1. April Cordova-Williams, M.A., LPC (Licensed Professional Counselor), NCC (National Certified Counselor)

2. My highest earned degree is a Masters degree in Counseling from Regis University of Denver (2014). I received a Bachelor of Psychology degree from The Metropolitan State College of Denver (2011). My theoretical orientation is based in the Person-Centered approach with the ability to integrate other beneficial techniques and/or approaches when necessary and beneficial.

3. Credentials and Affiliations: I am a candidate to be a Licensed Professional Counselor; I am a National Certified Counselor; I am a certified facilitator for Prepare/Enrich; I am a member of the American Counseling Association (ACA).

   April Cordova-Williams adheres to all code of ethics and regulations stated by the Following: American Counseling Association (ACA), American Psychology Association (APA), and National Board for Certified Counselors (NBCC)

ABOUT MY CLIENT RIGHTS:

4. The Colorado Department of Regulatory Agencies (DORA) has the general Responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapist, certified school psychologists, and unlicensed individuals who practice psychotherapy.

   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 masters degree in their profession and have two years of 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 1,000 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 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.

The agency within DORA that has responsibility specifically is the Mental Health Section, 1560 Broadway, Suite #1370, Denver, CO 80202, (303)894-7766.

5. Client Rights and Other Vital Information:

   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. Please ask me if you would like to receive this 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 DORA at (303) 894-7766.
   d. Generally speaking the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, 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 clinical social worker, and unlicensed psychotherapist, a licensed marriage and family therapist, a licensed professional counselor, or a licensed psychologist 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 legal exceptions to the general rule of legal confidentiality. <u>The exceptions Include</u>: intent to harm others or yourself; abuse or suspected abuse of children, and possibly the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges

in child-custody, divorce and other court cases. Also, be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding. There are other exceptions that I will identify to you as the situations arise during therapy.

6. I charge for counseling services on a negotiated sliding scale for persons paying for their own therapy. The scale is $60.00 an hour to $100.00 an hour based on 1/1000th of a client's annual income. The lowest minimum for service is $60.00 per hour. My normal fee is $100.00 per hour. Counseling sessions are provided in a 45 to 60 minute clinical meet. I only accept Cash or Credit Card as payment.

AS A THERAPY CLIENT I UNDERSTANDTHAT:

7. I understand that court testimony on your behalf is charged at a higher rate of $120.00 (1 hour minimum) including testimony related matters like case research, report writing, travel, depositions, and actual testimony and cross examination time and courtroom waiting time. Signing this disclosure statement gives permission for me to release confidential information in courtroom testimony and written reports to the Court.

8. I understand that there may be times when my therapist may need to consult with a colleague of another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client.

9. I understand that in marriage and family counseling, my therapist holds a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the therapist that requires differential or discriminatory treatment of family members.

10. I understand my therapist provides non-emergency psychotherapeutic services by scheduled appointment. If my therapist 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 therapist by telephone, (720-488-0878), and I am having a true emergency, I will call 911 or check myself into the nearest hospital, emergency room, or urgent care facility.

11. I understand that if I have any questions or would like additional information, I may feel free to ask during the initial session and at any time during the therapy process. By signing this disclosure statement I also give permission for the

inclusion of my partners, spouses, significant other, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist.

12. I understand that I am legally responsible for payment for my therapy services. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payor or anyone connected to my therapy funding source.

13. I understand that if I do not give 24 hours prior notice of cancellation to my therapist, I will be charged the full fee for not showing up for a scheduled therapy appointment. I understand that if another agency is paying for my services or for the services of my child and I do not give a 24 hour prior notice of cancellation to my therapist, I will be responsible for payment of the missed appointment session as I understand the other agencies do not pay for missed appointments. For example: Second Wind, Victim Compensation, Medicaid, CIGNA, and BCBS. By initialing this box I am advising that I am aware of the cancellation notice and understand the payment process to my therapist. ☐

14. I understand that, like any other professional service, I must pay for all therapy services (therapy in the office, telephone therapy, report writing, parental consultation, etc.) I receive as a client. If I do not pay for services received I understand I will be turned over to a collection agency to recover payment for my therapist. I also understand I must repay the full amount and any bank fees or other relevant costs to my therapist for bounced checks.

15. **CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT**

I have read the proceeding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. By signing this disclosure statement, I also agree to permit consultation and I provide release for my therapist to seek consultation with other therapists or professionals as the need arises. I also consent, if I use April Cordova-Williams, for me, my minor child, and/or any of my minor children to be observed and/or videotaped during therapy by staff, students and or treatment team members. I also affirm, by signing this form, that I am the legal guardian and/or custodial parent with legal rights to consent to treatment for any minor child or children that I am requesting therapy services from April Cordova-Williams MA, any staff, The One Day at a Time Counseling Center, or any Center students/interns.

Client’s Signature/or Parent of Minor	Date
Second Client’s Signature	Date
Therapist’s Signature	Date