DISCLOSURE STATEMENT OF

Amy Jensen, MA, LPC

Licensed Professional Counselor #15053

Amy Jensen Counseling, LLC

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Amy is a Licensed Professional Counselor (LPC) in the state of Colorado. She has experience working in many clinical areas including acute inpatient treatment, traditional outpatient therapy, and integrated behavioral health where she worked with child, adolescent, adult, and geriatric populations. In 2014 she obtained her undergraduate degree in Psychology from Colorado Mesa University and in 2016 gained a Master of Arts in Clinical Mental Health from Adams State University. With an integrated approach to evidence-based treatment she utilizes CBT, DBT, Narrative Therapy, Eye Movement Desensitization and Reprocessing, (EMDR) and other therapeutic techniques to create an environment tailored to each patients' specific needs.

Regulation of Psychotherapists:

This practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the division of Registrations. The regulatory boards can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303)894-7800. The regulatory requirements for mental health professionals provide that a Professional Counselor must hold the necessary licensing degree. Amy Jensen is a Licensed Professional Counselor practicing at Amy Jensen Counseling, LLC

Clients Rights and Important Information:

a. You are entitled to receive information from the clinician about their methods of therapy, the techniques they use, and the duration of your therapy and their fee. Please ask if you would like to receive this information.
b. You can seek a second opinion from another therapist or terminate therapy any time.
c. In a professional relationship (such as the one with your clinician), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the board that licenses, certifies or registers the therapist.
d. Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) The clinician is required to report any suspected incident of child abuse or neglect to law enforcement; (2) The clinician is required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) The clinician is required to initiate a mental health evaluation of a client who is imminently dangerous to self or others, or who is gravely disabled, as a result of a mental disorder; (4) The clinician is required to report any suspected threat to national security to federal officials; and (5) The clinician may be required by court Order to disclose treatment information.
e. Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from your clinician, they may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the HIPAA Notice of Privacy Rights you were offered as well as other exceptions in Colorado and Federal law.

Disclosure Regarding Divorce and Custody Litigation:

1. If you are involved in a divorce or custody litigation, your clinician's role is not to make recommendations to the court concerning custody or parenting time. The court can appoint professionals who can evaluate and make recommendations to the court concerning parental

responsibilities or parenting time in the best interests of the family's children. A goal of child and family therapy is to increase cooperation between litigating parents. In most circumstances, placing a clinician under subpoena is contraindicated. Please discuss these matters with the clinician so that the needs of your child and family are addressed properly.

2. If you have joint medical decision making both parents must consent to the child(ren)s treatment. If you have sole medical decision making only your consent is required.

Other policies:

Video/audio recording of ANY session without written permission from all parties involved is strictly prohibited and will result in IMMEDIATE termination of professional relationship and counseling services.

Payment Policies:

1. If you are paying out of pocket a fee of $85.00 will be collected at the time of service. This provider utilizes SonderMind to bill insurance and all fees will be managed through this portal. Any concerns with insurance should be directed through your insurance company or SonderMind. This provider bills Medicaid directly.

Cancelled Appointments:

Please provide at least 24-hour notice for cancellations if your appointment is not cancelled within the 24-hour time frame you will be charged an $85 cancellation fee for out-of-pocket clients. Medicaid clients are unable to be charged for a no-show, due to this a maximum of 2 no-shows will be allowed before therapy must be terminated. Clients with private insurance will be billed for the entire session through SonderMind. If cancellations need to be made a text message or voicemail be left on the business line, or by cancelling on the portal.

Emergencies:

I do not provide therapy outside of scheduled appointment times. In life-threatening emergency circumstances, I ask that you email AND call me so that we can create a short-term safety plan then follow-up therapy appointments. In the case that I am out-of-town/unavailable in the event of a life-threatening emergency, proceed to either St. Mary's Medical Center or Community Hospital emergency room, or Mind Springs Health Crisis to be evaluated for safety.

I have read the preceding information, and it has been presented to me verbally. I understand the disclosures that have been made to me. I also acknowledge that I have received a copy of this disclosure statement.

SIGNED:_____ **DATE:**_____

(Primary Client)

For Child Therapy, Marital Therapy, or Family Therapy, please sign as indicated.

SIGNED:_____ **DATE:**_____

(Parent or Spouse)

SIGNED:_____ **DATE:**_____

(Parent or legal guardian, child over 15 yrs.) **(Parent or legal guardian, child if over 15 yrs.)**