



## The Paraclete Group

P.O. Box 1507  
Eastlake, CO 80614-1507  
720.929.9406

### DISCLOSURE AND CONSENT FORM

Thank you for deciding to seek counseling with The Paraclete Group. The following information will help you understand many of the details about your therapy with Dr. Mitsch. A primary commitment of The Paraclete Group is to provide quality, time-effective treatment to individuals, couples, and families regardless of age, race, sex, or religious affiliation. Professional Christian counseling and the use of spiritual resources are available for patients who request it. Furthermore, Dr. Mitsch is committed to the patient's rights of information regarding practice policy, non-discrimination, confidentiality, consent, and competent services. In keeping with this policy, I have listed below the various practice policies for your information. Please read through these, ask any questions you may have, and sign on the other side. Thank you for allowing me to serve you.

The Colorado State Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. Professional Christian therapy is provided for clients who expressly request it. Although the exact length of treatment is difficult to predict, I will be glad to discuss the average duration for conditions similar to yours. I would also be more than willing to discuss what other treatment options might be available and the possible effectiveness of those alternatives. You may, at any time, seek a second opinion from another therapist and/or may terminate therapy.

Consistent with the established moral and ethical position of The Paraclete Group/Dr. Ray Mitsch, recent Colorado law requires that any individual seeking any counseling services must be informed that sexual contact between a patient and therapist is not part of any recognized therapy. ***Sexual intimacy between patient and therapist is never appropriate, is illegal, and should be reported to the Department of Regulatory Agencies, Mental Health Section by letter to 1560 Broadway, Suite 1340, Denver, CO 80202, or by phone at 303-894-7766. If you have any concerns or complaints about licensed mental health practitioners, you can contact the State Grievance Board.***

### PAYMENT POLICY

My policy is for each person receiving counseling or testing services to pay for such services **at the time the professional services are rendered.** Any other arrangements ***must be made in advance.*** **A \$32 administrative fee will be charged on all checks that are returned for non-sufficient funds.**

My fees are based on 45-50 minute sessions. My per-session fee is \$110. Phone consultations are the patient's responsibility and are billed in 15-minute increments. All calls over 5 minutes will be billed accordingly.

**Please note: Charges for testing services and educational resources are in addition to the regular per-session fee.**

### INSURANCE

Many insurance policies provide partial to total coverage of mental health services. Your insurance (personal, group, private, governmental, partial payment, or full payment type) is a contract between you and your insurance company; it is not an agreement between the insurer and Dr. Mitsch. ***I will not be responsible for filing your claims.*** My receipts are complete enough to provide all the information necessary for your insurance company to process your claim. There are many good reasons to seriously consider ***not*** using your insurance. Please ask me for further information regarding this issue, and how to make financial arrangements that are not a financial strain or burden for you.

## **CANCELLATIONS/MISSED APPOINTMENTS**

I understand that if may, at times, be necessary to cancel an appointment. To help me be the most efficient and responsible in the use of my time, I require that **any changes or cancellations be made at least 24 hours in advance of any workday, Monday through Friday.** If there were a need to cancel a Monday appointment, that cancellation would need to be made **by the Friday before the appointment.** If you have scheduled two 50-minute sessions on the same day and need to cancel, I will need **48 hours advance notice.** **Any changes or cancellations received less than 24/48 hours in advance may be charged the regular per-session rate.** **Any missed appointment with no call received will be charged the regular per-session rate.**

## **CONFIDENTIALITY**

Law protects the confidentiality of the counseling provided by Dr. Mitsch. Unless you grant me permission to do so in writing, I will neither inform anyone that you are receiving counseling, nor will I disclose the content of any session. The only circumstances under which such professional confidentiality may be broken is if one or more of the following conditions apply:

- If you pose a serious physical danger to yourself or to another person.
- If you disclose that you or another person has physically or sexually abused or molested a child, an incompetent or disabled person.
- If you disclose that a child, an incompetent or disabled person is suffering because of neglect.

If abuse or neglect is disclosed under the conditions given above, Colorado law to report such information to an appropriate state agency mandates me.

## **FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**

I authorize treatment of the person named below and agree to pay all fees and for such treatment. I agree to pay all charges promptly for me and members of my family shown by statements, upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date.

I attest that I have read this information sheet, that I have seen a brochure, am aware of my therapist's degrees and credentials, that I understand the conditions as stated above, and I agree to receive counseling under these conditions.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Signature of Spouse (when in joint therapy)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date