**Disclosure Form**

*Zachary Van Eps, M.A., NCC, LPC*

*1711 S. Pearl St., STE #1*

*Denver, CO 80210*

*(303)747-5457*

**Credentials and Professional Affiliations:**

University of Colorado Denver: *Master of Arts, January, 2013*

 *Counseling Psychology and Counselor Education;*

 *Couples and Family Track*

Licensed Professional Counselor #LPC.0012708

National Certified Counselor

EMDR trained therapist

Licensed Professional Counselor candidate

**State Requirements:**

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Mental Health Occupation Grievance Board can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

As to the regulatory requirements applicable to mental health professionals:

* Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
* 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.
* 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 of post-masters supervision.

Any person who alleges that a licensee, registrant, or certificate holder violated a provision of article 43 related to maintenance of records of a client 18 years of age or older must file a complain or other notice with the board within seven years after the person discovered or reasonably should have discovered the misconduct. A licensee, registrant, or certificate holder shall notify a client that the client’s records may not be maintained after the seven-year period for filing a complaint pursuant to this section.

**Client Rights:**

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

**Client Therapist Relationship:**

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. The client-therapist relationship is a professional relationship. We will not accept gifts that value more than $10.

**Fees and Policies**

The cost for therapy is $100 per session. It is expected that you make payment for therapy prior to the start of each session. We accept cash, check, and most major credit cards. Solace Counseling LLC currently accepts Cigna Insurance only. Also, please note that we do not accept bartering in exchange for counseling services. Every client must provide a credit card to be kept on file for cancellation charges.

Should you need to cancel or reschedule an appointment, I ask that you grant me at least 24 hours notice of the schedule change. Clients will be charged a full session fee for cancellations made within 24 hours of the scheduled appointment.

**Confidentiality:**

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 (made available at your request), as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

**I have read and fully understand the above information regarding treatment at Solace Counseling LLC. I have been informed about my rights as a client as well as the limits of confidentiality.**

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**Client Name (Printed)**

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**Client Signature** **Date**

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**Parent/Guardian Name (Printed)**

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**Parent/Guardian Signature**  **Date**