MELISSA PRESTON
COUNSELING

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Client- Therapist Agreement

Welcome!
This form will answer most of your questions about therapy services at my office. Please feel free to ask additional questions to clarify anything at your initial session.

My Degree information:

Licensed Professional Counselor:
Colorado Licensure Number: 12455
Issue Date: May 2015

Masters of Arts in Counseling Psychology
University of Colorado Denver
Issue Date: May 2013

Registered Dietitian Certification
National License Number: 933352
Issue Date: March 2003

Bachelors of Science in Nutrition
Colorado State University
Issue Date: May 2002

What is therapy and how does it work? Therapy is a collaborative process between myself, the counselor, and you, the client, and works on solving emotional problems so that you may live a more fulfilling and happier life. The process of change is often difficult and may exacerbate your symptoms initially, however, over time you should see an improvement. The most important factor for success in therapy is good communication between you and me. If at any time, you feel your needs are not being met, I invite you to express these concerns so they can be worked through.

Clients Rights and Limitations of Service

1. You are entitled to information from me about my approach to therapy, techniques, and the duration of therapy
2. You can seek a second opinion from another therapist or terminate therapy at any time.

3. My fee is $140 per 50 minute session of therapy or nutrition. My fee is $210 per 75 minutes of therapy and nutrition. Payment must be made at the time of service in the form of cash, check, or credit card. I do not accept insurance for services rendered. If you would like to submit a bill to your insurance company for reimbursement I will provide you with a form at the end of each month. Please inform me if you would like this form. Checks need to be made out to Melissa Preston Counseling. There is no charge for brief phone conversations between sessions or for emails. Any phone conversation extending beyond 10 minutes will be billed according to the pro-rated hourly fee.
4. **PLEASE NOTE: Clients may choose to email, text or utilize social media (such as Melissa Preston Counseling's Facebook page) to contact their therapist. These modes of communication, while protected with passwords specifically chosen by the therapist, cannot be guaranteed as confidential forms of communication
5. In a professional relationship, sexual intimacy is never appropriate and is illegal in the state of Colorado. If sexual intimacy occurs, it should be reported to the State Grievance board.
6. By law and professional ethics, our sessions are strictly confidential. Generally no information will be shared with anyone without your consent and release of information. There are however a number of exceptions to this rule:

a. Supervision and consultation with a colleague when I feel this is necessary for guidance regarding any issues that come up in therapy.
b. I am required to report any suspected incident of child or elder abuse or neglect to law enforcement.
c. I am required to report any threat of imminent physical harm by a client to law enforcement and to the persons(s) threatened.
d. I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others.
e. I am ordered by the court to testify or release records
f. There is a release of information given by you, the client.
g. I am seeing a minor aged 15 or under and parents request information.

7. I provide non-emergency psychotherapeutic services by scheduled appointment. 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, (303) 489-9269, and are having a true emergency, you should call 911 or check yourself into the nearest hospital emergency room immediately if your personal safety or mental health is at stake.
8. Sometimes in psychotherapy things get worse (because of repressed issues and systematic dynamics) before things get better. By signing this, it states that you understand this may be a natural part of the psychotherapeutic process.

Regulation of Psychotherapists:
The Colorado Department of Regulatory Agencies is responsible for regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors,

licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has the responsibility specifically for licensed professional counselors is the Board of Licensed Professional Counselor Examiners, 1560 Broadway, Suite #1370, Denver, Colorado, 80202, (303)894-7766.

Cancellations: You will be charged for all cancelled appointments if not done within 24 hours (weekends and holidays excluded) of your appointment. You may leave a message on my voice mail (303) 489-9269 24 hours a day, seven days a week to cancel an appointment. All Monday appointments must be cancelled or rescheduled by the Friday prior to the appointment.

Treatment Planning:
Periodically, client and therapist will assess progress toward treatment goals. It can be mutually beneficial if termination is discussed in advance. In the event that 60 days transpires since the last scheduled appointment, it will be assumed that treatment it terminated. A client may choose to re-engage in the therapy process at any time but must contact the therapist to re-establish treatment services.

I have read the preceding 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 psychotherapist(s) to seek consultation with the agency that referred me and/or my minor children, other psychotherapists or professionals as the need arises. 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 by Melissa Preston. This disclosure statement will be automatically revoked one year after signing in compliance with HIPAA guidelines.

I have received a copy of the NOTICE OF PRIVACY PRACTICES. _____Client Initials

____________________________	____________________________
Client Name (printed)	Parent/ Guardian (printed)
____________________________	____________________________
Signature	Signature
____________________________	____________________________
Date	Date