Caitlin Kozicki PLLC
7220 W. Jefferson Ave., Ste 218
Lakewood, CO 80235
303-957-6504
Ckozicki98@gmail.com

Disclosure Statement & Policies

This disclosure statement of practice and office policies will help you clearly understand your rights and responsibilities as a client. It should be read carefully. Your signature on the last page of this document represents an agreement between us. Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for their minor child/ren, must sign this disclosure statement on behalf of their minor child under the age of fifteen (15) years old. This disclosure statement contains my policies and procedures and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal Regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

My Education and Credentials:

Bachelor of Arts in Psychology: Montana State University, 2002

- Required 120 hours of credit hours of coursework.

Master of Counseling Psychology: Pacific University, 2006

- Required 63 credit hours of coursework and 700 hours of clinical experience.

Licensed Professional Counselor (LPC), #5209

- Required a Master's Degree in counseling psychology, 2,000 hours of clinical experience, a passing score on the National Counselor Exam, and 100 hours of clinical supervision.

Certified Addiction Counselor III (CAC III), #6733

- Required a Bachelor's Degree in behavioral health, complete additional required training hours, and 2,000 hours of supervised experience.

Certified Employee Assistance Professional (CEAP)

- Required a clinical Master's Degree, 1,000 hours of working in an Employee Assistance Program (EAP) setting, 12 hours of advisement, 20 professional development hours, and a passing score on the CEAP exam.

National Certified Counselor (NCC)

- Required a Master's Degree in counseling psychology and a passing score on the National Counselor Exam.

My Methods:

I use a combination of different therapeutic techniques, including cognitive-behavioral, solution focused, EMDR (Eye Movement Desensitization and Reprocessing), and motivation interviewing techniques. There may be risks and benefits involved in all of these types of therapy. If you ever have a questions or concern about my methods, please ask me about them.

Regulatory Requirements:

The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Professional Counselor Examiners and Addiction Counselors regulate Licensed Professional Counselors and Addiction Counselors respectively, and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through my internal process.

Levels of Psychotherapy Regulation in Colorado include licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

The regulatory requirements applicable to mental health professionals:
Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. **Certified Addiction Counselor II (CAC II)** must complete additional required training hours and 2,000 hours of supervised experience. **Certified Addiction Counselor III (CAC III)** must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. **Licensed Addiction Counselor** must have a clinical master's degree and meet the CAC III requirements. **Licensed Social Worker** must hold a masters degree in social work. **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 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. **Registered Psychotherapist** is a psychotherapist listed in Colorado'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. Registered psychotherapists are required to take the jurisprudence exam.

Your rights:
You have the right to:

- Terminate therapy at any time.
- Seek a second opinion from another therapist at any time.
- Revoke the release or disclosure of confidential information at any time, in writing and given to me.
- Receive information about my methods of therapy, the techniques I use, the duration of therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.
- 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 the Department of Regulatory Agencies, Mental Health Section and the Boards listed above.

Confidentiality:
Generally speaking, the information provided by and to the client during therapy sessions is legally confidential. Confidential information cannot be released without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the information sought relates. 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 provided as well as other exceptions in Colorado and Federal law. Some limits of confidentiality are:

- Threat of harm to self or others, which includes those identifiable by their association with a specific location or entity, including grave disability
- Known or suspected child abuse
- Known or suspected elder abuse, which includes exploitation of an at-risk elder
- Court order, or other mandate of State and/or Federal Law
- Written consent from the client
- In the investigation of a complaint or if you file a civil suit against me

You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. If a legal exception arises, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out the Consent for Communication of Protected Health Information by Unsecure Transmissions.

Services provided & referrals:
Services included will be an assessment, counseling, and referrals to community services as needed. If it is determined following the assessment that the presenting issues require services beyond my scope as a provider, you will be provided referrals either through your insurance carrier or to a provider in the community that can provide more specialized therapy. This will be discussed with you. I am legally required to refer, terminate, or consult if your issues are beyond my scope of practice.

Consultation:
The competent and ethical practice of psychotherapy dictates that I participate in regular case consultation with other licensed professionals. These other professionals are also legally bound to keep any information discussed confidential. Should I obtain consultation regarding aspects of your treatment, I will omit identifying information (including your name, place of employment, etc.) so that your confidentiality will be preserved to the best of my ability. Your signature on this policy serves as consent that I may obtain consultation regarding your treatment (on an anonymous basis) without a specific release to do so.

HIPAA:
You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA)**.** This law insures the confidentiality of all electronic transmission of information about you. If I transmit information about you electronically (e.g., e-mailing or faxing information), special safeguards will be utilized to ensure confidentiality. This form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, you agree you have received my Notice of Privacy Policies and Practices and acknowledge receipt of the policy or have waived receiving the Notice at this time. You may receive a copy of the Notice of Privacy Policies at any time and it is also listed on my website.

E-mails:
Please note that the confidentiality of e-mail communication is not secure, and therefore I try to avoid it as much as possible when communicating with you about your treatment. If you e-mail me about something related to treatment, you are consenting to use e-mail with full knowledge that it is not a secure medium. E-mails can be used for asking simple questions, asking about rescheduling an appointment, a quick update, etc. E-mail may also be used for appointment reminders and self-help information.

Health Care Coordination:
It is important to make sure that the problems you present are not related to a physical health issue. Since I am not a medical provider, I cannot determine if you have a physical condition that might be related to your mental health and reason for accessing services with me. Therefore, if you have not had a physical examination in the past 12 months, you should get one as soon as possible. It would be best to tell your medical provider that you will be working with me so

that we might begin to coordinate your health care. With your written authorization, I may obtain your medical records so I have a better understanding of your overall health.

Appointments:
We will schedule our appointments via phone or in person. You may call me at 303-957-6504 to schedule an appointment. My office hours are typically Tuesday through Saturday and I will make every effort to honor and accommodate your appointment preference. Our appointment length will be discussed and determined (**50, 60, or 90 minutes long)**. We will start and end on time. I cannot accommodate making up for lost appointment time unless it is due to my error or tardiness. You agree that I may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you in accordance with my Consent for Communication of Protected Health Information by Unsecure Transmissions.

No Secrets Policy:
I, the client, understand that in marriage and family counseling, Caitlin Kozicki holds a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept by Caitlin that requires differential or discriminatory treatment of family members. I understand that any information shared in any individual therapy MUST be also shared in couple or family therapy to insure this "NO SECRETS" policy. Caitlin may give the individual an opportunity to disclose something but she will not lie or refuse to answer any question posed by another member. I understand that Caitlin will refer me to another counselor should I want to discuss something and have it be kept confidential from the other members. This pertains to all face-to-face, written, and phone conversations and messages. Signing this disclosure statement affirms permission for my psychotherapist to share this confidential information as deemed necessary for treatment. **I understand that Caitlin cannot be subpoenaed to testify or produce records without consent and authorization from all parties.**

Missed Appointment/Late Cancellation:
Cancellations/rescheduling must be arranged at least **24 hours before the appointment by phone/text (303-957-6504).** If an appointment is missed or cancelled/rescheduled within 24 hours of the appointment ("late cancel"), you will be charged for the cost of the session. All no show/no call appointments will be charged the entire amount of the scheduled session.

Clients will not be charged for the first "late cancel" due to illness each year. Additional late cancellations due to illness will be charged the entire amount of the scheduled session. Please be sure to call 24 or more hours in advance if you are concerned that you may not be well at the time of your appointment.

In case of inclement weather, a challenge with transportation, or any reason you are unable to reach my office for an in-person appointment, you may have the option to attend the appointment via phone. This needs to be coordinated prior to the start time of your scheduled appointment. Otherwise the appointment will be cancelled/rescheduled.

Standing Appointments:
The late cancellation policy applies to all standing appointments. A standing appointment are those made on a weekly, biweekly, or monthly basis.

Payment, co-pay, or co-insurance:
Payment is due at the time of service. If using third party reimbursement (health insurance) the co-pay or co-insurance is due at the time of service. You are fully responsible for payment should your insurance not cover one or more sessions.

I, the client, understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payor, etc. does not compensate my therapist I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate

with my insurance company, HMO, third-party payor, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance company receives the information I or my therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report she submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.

Appointment Length:
Counseling appointments are either **50, 60, or 90 minutes** in length. This will be discussed and determined with you. Please reference the fee agreement for the price per session.

Fees:
It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

The request for legal services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $300.00 per hour.

Record Keeping:
I will keep brief records, noting that we have met, what interventions were used in appointment, and the topics discussed. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make copy of your file available to any other health care provider at your written request. I maintain your records on a secure hard drive and/or in a locked filing cabinet that cannot be accessed by anyone else. I do not maintain records electronically. However, emails are considered part of your client file but are not secure. Please use discernment when communicating via email. I have entered into a Business Associates Agreement with my email service provider, Gmail for Work. This means that my email service provider is obligated by federal law to protect the information stored in the emails from unauthorized use or disclosure. **THIS DOES NOT MAKE EMAIL COMMUNICATIONS SECURE.**

Limitation of Services:
I do not offer 24-hour care. If you need after-hours care, I will assist you in finding the proper resources. If you are experiencing a mental health emergency, call Rocky Mountain Crisis Partners (1-844-493-8255) or 911 immediately. You can also contact the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), Metro Crisis Services at 1-888-885-1222, or Postpartum Support International support helpline at 800-944-4PPD (4773) or go to your nearest emergency room. **If you must seek after hours treatment from any counseling agency or center or hospital, you understand that you will be solely responsible for any fees due**. If you leave a voicemail on the phone number provided, I will return your call by the end of the next business day, excluding holidays and weekends.

Teletherapy:
In general, I do not provide Teletherapy, such as therapy over telephone or video chat. Should you desire Teletherapy, please discuss this request with me. It is within my sole discretion whether to accommodate your request for Teletherapy.

Social Media:
I do not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I have, or may have, a business social media account page. There is no requirement that you "like" or "follow" this page. Should you choose to "like" or "follow" my business social media page others will see your name associated with "liking" or "following" that page. This applies to any comments that I post on the page/wall as well. Any comments you post regarding therapeutic work between us will be deleted as soon as possible. You agree to refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. You agree that if you have a therapeutic comment and/or question that you will contact me through the mode you consented to and **not** through social media. Please let me know if you have any questions regarding social media, review websites, or search engines.

Extraordinary Events:
In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Shannon Schou
ADDRESS: 1776 South Jackson St Suite 700, Denver CO 80210
TEL: 970-222-7478
CREDENTIALS: LCSW (#9923319), LAC (#287)

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Counseling relationship and professional boundaries:
I will not, at any time, have a social relationship with you outside of my office, whether we have ended our therapy relationship or not. I will not accept social or family invitations from you, and I will not offer them to you. This is not for a lack of interest or care but in order to maintain professional boundaries.

To ensure your confidentiality as a client, if I were to see you in public at any time, I will not initiate any contact or familiarity with you beyond basic pleasantries. If you choose to initiate a visible or audible greeting, I will reciprocate but will not attempt further communication unless you request it.

Consent for Treatment of Minors:
If you are consenting to treatment and therapy services for minor child/ren that I request that you produce the Court Order Custody Agreement and/or Parenting Plan that grants you the authority to consent to mental health services for the minor child. Further, you understand and agree to keep me informed of any proceedings or supplemental court orders that affect your parenting rights, custody arrangements, and decision-making authority. You understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit me from providing therapy to your minor child/ren. It is beyond the scope of my practice to provide custody recommendations. Any request for

custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

Risks & Benefits:
During the course of therapy, you might notice changes in your symptoms, problems, and/or functioning. Since we will be exploring challenging territory for you personally, in your relationships and/or life, you might experience greater difficulty throughout our work. However, as you work through your areas of difficulty and build upon your strengths, it is likely that you will see improvements throughout our work and in your future. **Please be advised that counselors cannot guarantee successful therapy outcomes.**

Discontinuing Therapy:
Should you choose to discontinue therapy for more than sixty (60) days by not communicating with me, your treatment will be considered "terminated." You may be able to resume therapy after the sixty (60) day period by discussing your desire to resume therapy services with me. Ability to resume therapy after sixty (60) days will depend upon my availability and will be within my sole discretion. This disclosure statement will remain in effect should you resume therapy if one (1) year has not elapsed since your last session. However, you may be asked to provide additional information to update your client record. You understand "discontinuing therapy" means that we have not had a session for at least sixty (60) days, unless otherwise agreed to in writing.

Ending Counseling:
You normally will be the one who decides counseling will end, with two exceptions:

- If I am not, in my sole discretion, able to help you because of the kind of problem you have or because my training and skills are not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.
- If you are violent or threatening toward myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment.
- If I end counseling with you, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

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Your signature indicates an informed consent to counseling and agreement to the following:

I have read the Disclosure Statement & Policies and understand it.

I have had the opportunity to ask Caitlin Kozicki LPC, CAC III, CEAP questions and to be provided further explanation pertaining to the Disclosure Statement & Policies.

I agree to follow the terms, policies, and responsibilities in the Disclosure Statement & Policies.

I understand that payment including any applicable co-pay or co-insurance is due at the time of service.

I have read the preceding information or it has also been provided verbally if I am unable to read or have no written language, and I understand my rights as a client or as the client's responsible party.

Client signature: _____ Date: _____

Client Name (printed): _____

Counselor signature: _____ Date: _____
Counselor Name (printed): Caitlin Kozicki LPC, CAC III, CEAP