PSYCHOTHERAPY AGREEMENT

I hereby give my consent for psychotherapy. My initials and signature in the spaces provided below indicate that I have read and understand this consent for treatment, that any questions which I may have had regarding this form have been answered to my satisfaction, and that I agree to the following:

1. I understand that the services which I am consenting to receive include evaluation and treatment by Marc J. Coulter, LPC, CAC III. I understand and acknowledge that no guarantee, read or implied, has been given nor promise has been made that a specific outcome will result from my evaluation and treatment. I further understand that I may choose to discontinue treatment at any time. Client Initials _____

2. I understand that treatment is conducted in a drug free environment and that, therefore, I must disclose to Marc, the use of any medication, including both prescription and over-the-counter, which I may be taking at the time of admission. Client Initials _____

3. I understand that the full fee for clinical services is $145 per 50-minute session and $215 per 90-minute session. Any excessive case consultation, documentation, or telephone contact will be billed at a pro-rated rate of $145 per hour. Court testimony on your behalf is charged at a rate of $400 per hour including case research, report writing, travel, depositions, testimony, cross examination time and courtroom waiting time. Client Initials _____

4. 24-hour notice is expected for appointment cancellations. Cancellations with less than 24-hour notice or "no shows" will be billed at a rate of $145 each. I understand that if I miss or cancel my appointment late due to a minor illness, I will be charged my regular session fee. Hospitalization or other imminent and major medical conditions of the client or an immediate family member may be excused. I will not be charged for weather related cancellations if local school districts and businesses are closed due to weather, however I will be charged my usual fee if the majority remain open. Insurance (if using) does not cover late cancellation/no show appointments, and I am responsible for the full fee. Payment is expected at the time at which the services are provided. Excessive "no shows" or cancellations may result in discharge. Client Initials _____

5. I understand that if I am using insurance benefits, I am responsible for any fees not covered by my insurance. I further understand that if my insurance benefits are declined, I am responsible for full fee payment. If utilizing insurance benefits, I understand that they require a diagnosis and that the insurance company has the right to request my treatment records during or after treatment. Client Initials _____

6. I understand that social media connections, or "friending," are not acceptable in a therapeutic relationship such as ours. I understand that Marc will not connect via LinkedIn, Facebook, or other social media sites. Client Initials _____

7. I understand that any outstanding fees will be turned over to a collection agency, and I consent to release any necessary information needed in order to collect fees owed. Client Initials ____

8. I have/have not (please circle) received any mental health or substance abuse treatment within the two years prior to this admission. I understand that Marc may need to request access to these records for continuity of care. I agree to sign the needed releases of information to allow access to these records if Marc requests. Client Initials _____

9. I understand that I will be considered an "inactive" client and my file will be closed after two weeks of lack of contact with Marc unless otherwise agreed. A client's file may be reopened and considered "active" if a client reengages in services with Marc. Client Initials_____

10. I understand that emails, texts, and cell phones are not secure forms of communication and that confidentiality can not be guaranteed when using these forms of communication. Client Initials___

EMERGENCY AND CONFIDENTIALITY

In case of emergency, contact Marc Coulter at 303-388-9749, leave a detailed message explaining the emergency, and follow the directions on the voice mail to call the Colorado Crisis Care hotline at 844-493-8255, call 911, or go to your nearest emergency room.

All information disclosed during the course of treatment is confidential and will not be released without signed consent from you. There are exceptions to confidentiality:
1. Any explicit or implied serious and foreseeable threat of harm to self or others.
2. Any disclosure of past or current child abuse or abuse of an incapacitated adult.
3. A court order to release your information, or if you file a complaint or lawsuit again Marc
4. Any crime committed against Marc or the agency.
5. If you are in need of emergency medical attention while at the office, Marc will need to contact emergency medical personnel to inform them of your condition in order to help ensure your own safety.

In addition to these, if you are receiving couples or family therapy, all information which you disclose is available to any other family members who are participating in this therapy.

In Colorado, clients age 16 and above are able to seek counseling without parental consent.
If the primary client is a minor under the age of 18, necessary information regarding the client's treatment will be provided to the parent whose signature is on this agreement. Reasonable effort will be made to protect the minor's confidentiality, yet it is acknowledged that the parent must have access to critical information. If it is determined that the parent needs to know additional information about the minor, reasonable effort will be made to have the client disclose this information to his/her parent prior to having Marc reveal this private information. In the event that time sensitive information has been disclosed by the minor, Marc may inform the parent without the minor's consent.

I have read and understand this Psychotherapy Agreement, and I agree to abide by its content:

_____   _____
Client Signature   Date

_____   _____

_____   _____

_____   _____
Parent Signature (for minor clients)   Date