

**Aurora Mental Health Center or  
Asian Pacific Development Center  
Disclosure and Consent to Treatment**

**Clinician Name:** \_\_\_\_\_ **Credentials:** \_\_\_\_\_ **Supervised by:** \_\_\_\_\_

**Business Address:** 1290 Chambers Rd, Aurora, CO 80011 **Phone:** 303-617-2300

**Client Representative:** Julia Lamb & Jen McBride

**Phone:** 303-617-2343

You may contact a client representative if you have any concerns or complaints about the way you have been treated or about the services you have received. Organization in this document refers to AuMHC and APDC. You may also contact:

<p><b>Aurora Mental Health Center or Asian Pacific Development Center</b> 1290 Chambers Road Aurora, CO. 80011 (303) 617-2300</p>	<p><b>Colorado Office of Behavioral Health</b> 3824 W Princeton Cr. Denver, CO 80236 (303) 866-7400</p>	<p><b>Colorado Access</b> PO Box 17950 Denver, CO 80217-0950 720-744-5134 or 877-276-5184</p>	<p><b>Office of Civil Rights</b> <i>Concerning discrimination complaints</i> 999 18<sup>th</sup> St, South Terrace, Ste 417 Denver, CO 80202 (303) 844-7915</p>
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The practice of both licensed and unlicensed persons in the fields of psychotherapy and addiction services are regulated by the Department of Regulatory Agencies. Questions, complaints and grievances may be directed to the Boards of Psychology, Professional Counseling, Social Work, Addiction Counselors, and Marriage and Family Therapy at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. Please see "Client Rights" for additional information.

**Consent to Treatment:** I consent to and authorize the organization's healthcare team, including providers in training, to perform mental healthcare and/or addiction evaluation and treatment as deemed medically necessary in their professional judgment.

**Confidentiality:** I understand that my records will be held in confidence according to the policy of the Center as defined by the Colorado Revised Statutes (CRS section 12-43-218), the code of Federal Regulations (42 C.F.R. Part 2) and the organizations' Notice of Privacy Rights. There are exceptions to the rule of confidentiality that will be identified to you should any such situations arise during therapy. In general, the exceptions include a "threat of serious harm to yourself or others" as in the case of child or elder abuse, suicide, grave disability; under a court order; or in response to any legal action taken by you against this agency.

**Research & Follow-up:** I understand that any Protected Health Information disclosed for research purposes will be covered under separate consent forms. I understand the Center may contact me after termination of treatment to gather information needed for follow-up and program evaluation.

**Destruction of Records:** I understand that the clinical records may be destroyed if no further treatment is rendered within 7 years of the date of termination of this episode (or 7 years from the date client reaches age eighteen, if client is a minor.)

**Client Financial Responsibility:**

- All fees are due at the time of service.
- If I qualify for sliding fee scale-based services and my financial situation changes, I will contact this organization's staff to make new payment arrangements.
- I understand that this organization may revise Standard Fees at any time, which may impact my fees.
- I agree to pay all costs including reasonable attorney fees in the event organization refers unpaid fees for collection.
- If and when there are changes to my insurance coverage, or financial situation that will impact my financial obligations, I will notify this organization's staff and make other financial arrangements for payment of services if needed.

**Assignment of Benefits and Release of Information:**

- I agree to be responsible for my co-payment, deductibles or other charges for services not covered or paid by insurance or other third party payers except as prohibited by any agreement between my insurance company and this organization or

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by state or federal law.

- I authorize the organization to file any claims for payment of any portion of my bill and assign all rights and benefits payable for services to this organization until final payments are made.
- I authorize this organization to release any information necessary, including mental health/substance abuse records, to process claims as required by my insurance or third party payers until final payments are made.

**Failure to cancel appointments at least 24 hours in advance**, or not showing up for an appointment, may result in a fee of up to \$30.

**Please Initial:**

\_\_\_ I have been informed of my counselor's degrees, credentials and licenses, verbally and on this form.

\_\_\_ I acknowledge that I am consenting to treatment at this organization. Treatment services delivered via audiovisual and telephone (telehealth) are where I would interact with a provider in a live format but who is not physically present with me. I understand and agree that neither party will record the service without consent of the other party. I will let staff know if I prefer to receive services in person, AuMHC will attempt to accommodate my request. I understand that I may change my preference to receive telehealth services at any time for any reason.

\_\_\_ I agree to the payment terms defined above.

\_\_\_ If this organization is not an in-network provider with my insurance plan/payer, I have been informed of this.

\_\_\_ I acknowledge that I have received a copy of my rights as a client.

\_\_\_ I acknowledge that I have received a copy of the Center's Notice of Privacy Rights.

\_\_\_ I acknowledge that I have read and received a copy of the information on both sides of this page.

**I certify the above information I have provided is correct to the best of my knowledge.**

Client/Parent/Guardian Signature	Date	Staff Name (print) and Signature	Date
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**We provide services in accordance with the following guidelines:**

- You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure
- In a professional relationship, sexual intimacy is never appropriate and is illegal in Colorado. It should be reported to the Board that licenses, registers, or certifies the provider
- If you participate in group therapy, it is necessary for you to agree to protect and respect the privacy of other group members. You need to agree not to share personal information, including the names of other group members, with people outside of the group. You may expect other group members to show the same respect for your confidentiality.
- As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker (LCSW), a

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Licensed Marriage and Family Therapist (LMFT), and a Licensed Professional Counselor (LPC) must hold a master's degree in their profession and have two years of post-masters supervision. A Licensed Psychologist (PhD, PsyD) must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker (LSW) must hold a master's degree in social work. A 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. A Certified Addiction Technician must be a high school graduate, complete required testing and training hours and 1000 hours supervised experience over a minimum of 6 months. A Certified Addiction Specialist must have a bachelor's degree in behavioral health, complete additional testing and required training hours and 2,000 hours of supervised experience over a minimum of twelve months. A Licensed Addiction Counselor (LAC) must have a clinical master degree, meet the Certified Addiction Specialist requirements and have 3,000 hours of work experience. An Unlicensed Psychotherapist is registered with the State Board of Unlicensed Psychotherapists, is not licensed or certified, and no degree, training or experience is required. This organization will inform you if you are working with a therapist with an out-of-state license.