

Client-Therapist Agreement
Deep Roots Counseling, LLC
Alicia Brock, MA, LPC
2101 S. Blackhawk Suite 240
Aurora, CO 80014
720-446-6549

Hello, and welcome to Deep Roots Counseling, LLC. In this form you will find information and guidelines for therapy that will be helpful to know and refer back to as we progress. Please read this form carefully, as you will be requested to sign that you understand and agree to the terms of service. We will discuss each of the items in person, so you will have a chance to have any questions answered at that time. The purpose of this form is to inform you of your rights which are protected by legal, professional and ethical standards.

Background and Approach:

I obtained a Bachelor of Arts degree in Psychology and Sociology in 2000 from Southwest Baptist University. I also obtained a Master of Arts degree in Clinical Mental Health Counseling in 2012 from Denver Seminary. I am a Nationally Certified Counselor and am licensed with the State of Colorado as a Licensed Professional Counselor.

My approach to therapy is eclectic, but generally comes from the belief that we are all affected by the relationships and "systems" that we operate in. Some examples of those systems include family, social groups and work relationships. In order to understand ourselves more fully, I believe it is important to examine how these systems function and how each person functions in relation to those around them. To do that I may employ a variety of techniques based in Gestalt, Person-Centered, Narrative and Cognitive Behavioral Therapy. When working with children, I use both non directive and directive play therapy as well as some family therapy.

Risks and Benefits:

As a client, you will have an opportunity to discuss issues in your life that may be affecting your work, studies, relationships or family. In order to fully explore these issues, you may experience some discomfort. The process of change is often difficult and may exacerbate your symptoms initially, however, over time you should see an improvement. There is no guarantee, however that you will experience the change you wish to see. A therapeutic relationship will require time, commitment, and responsibility of both the client and the therapist. 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.** I may, from time to time, check in with you to ensure I am meeting your needs in the best way possible.

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 \$120 per 50 minute session of counseling. Payment must be made at the time of service in the form of cash or check. The only insurance I accept is Medicaid through Adams, Arapahoe and Douglas Counties. If you would like to submit a bill to your insurance company to see if they will reimburse you, I will be happy to provide you with an insurance form at the end of each month.
- 4.** All cancellations must be made no later than 24 hours prior to your scheduled appointment. If cancellations are not made 24 hours prior, I reserve the right to charge your credit or debit card, which I will keep on file.
- 5.** There is no charge for brief phone conversations between sessions or for emails. Any phone conversation extending beyond 15 minutes will be billed according to the pro-rated hourly fee.
- 6.** My fee for any participation in legal proceedings (eg: court appearances, preparation for court appearances, travel, report writing) is \$250/hour.
- 7.** While I make every possible effort to ensure our electronic communication is confidential, I cannot guarantee this. As such, electronic communication will be limited to scheduling appointments. I will not respond to any information beyond this via email or text.

- 8.** 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.
- 9.** In order to protect your confidentiality and keep appropriate professional boundaries, I will not connect with you on Facebook, Google +, Linkdin, Twitter or any other social media site.
- 10.** The information provided by the client during therapy sessions is legally confidential except for the following situations:
 - a. When you represent a potential danger to yourself
 - b. When you represent a potential danger to others
 - c. When there is reasonable suspicion of child abuse, elder abuse, neglect or sexual abuse presently or in the past
 - d. A court order requiring release of information
 - e. There is a release of information given by you, the client.
 - f. I am seeing a minor aged 15 or under and parents request information.
- 11.** In family counseling, I hold a "NO SECRETS: policy. All members of the couple or family system are treated equally and "secrets" are not kept by me that require differential or discriminatory treatment of family members. By signing this it states that you understand that any information shared in any individual therapy must be also shared in couple or family therapy to insure this "NO SECRETS" policy. Signing this disclosure statement affirms permission for me to share this confidential information as deemed necessary for treatment.
- 12.** 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, (720) 446-6549, 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.

13. 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.

Supervision:

To assure the quality of your care, I will regularly consult with individual and group supervisors regarding your treatment. My supervisor is Dr. Stacey Bromberg. I will be discussing our work with her for the purpose of my own training and development. She is also bound by confidentiality laws and is unable to violate these rules except under the circumstances listed in this consent form (e.g. threat to self/others, abuse / neglect, subpoena, permission from the client). Please let me know if you have any questions about this. My supervisor's contact information is:

Stacey Bromberg, PhD
950 S Cherry St #1240,
Denver, CO 80246
(720) 505-3772

I have read the above statements and agree to the terms of service

Client (Parent/guardian if child is under 15) Signature

Date

Client Signature

Date

Therapist Signature

Date