Rachel Bédard, Ph.D.
Licensed Psychologist (CO #3090)
1302 South Shields, A 2-1
Fort Collins, CO 80521
(970) 391-9628

Today's date_____________

Child's Name____

Date of Birth____

Parent/Guardian names ___________________________________

Mailing Address ____

____

Phone numbers _________________________

Email ____________________________________

School __________________________________

Current Grade____________________________

Physician's name__________________________

Emergency contact name and number ____________________________

** All parents/guardians with parental rights must sign ALL these forms where indicated, though not all responsible parties are obligated to attend the first appointment. It is your responsibility to get the signatures prior to arriving to your first appointment. **

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www.DrRachelBedard.com

Disclosure and Information Form

1. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: a 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. A Licensed Social Worker must hold a masters 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 Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelors degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

2. You are entitled, to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

3. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

4. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

   I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

____
Print Client's name

____ ______________________
Client's or Responsible Party's Signature Date

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Policy Regarding Confidentiality

One of your most important rights as a client involves confidentiality. Within certain limits, information revealed by you during therapy sessions will be kept strictly confidential. It will not be revealed to any other person or agency without your written consent.

You should also know that there are certain times when, as a mental health professional, your therapist is required by law to reveal information obtained during therapy to other persons or agencies even without your consent. Also, your therapist is not required to inform you of such actions in this regard. Even so, he or she will most likely discuss with you such potential disclosures before they are made. The times when your therapist must reveal information to other persons or agencies are as follows:

1.) If you threaten grave bodily harm or death to another person, your therapist is required by law to take reasonable care to protect that other person. This may include telling the intended victim and/or appropriate law enforcement agencies.

2.) If you indicate a serious intention to harm yourself, your therapist may take steps to prevent such harm from occurring.

3.) If a valid court order is issued, your counselor may be required by law to provide the information specifically described by the court.

4.) If there is reasonable cause to believe that a child or "at-risk" adult may be abused or neglected, your therapist is required by law to report this to the Department of Social Services or the local law enforcement agency. "Abuse or neglect" means an act or omission on the part of any person which seriously threatens the health or welfare of the child or "at risk" adult. This includes abuse that is occurring now or that has occurred in the past.

5.) Threats to national security must be reported to the proper authorities.

Please discuss any questions you have about the above information with your therapist.

I have read and understood the conditions of clinical services described above and hereby give my consent to receive services under these conditions. I have been given a copy for my personal files.

____ Date: _____________________
Client Signature

____ Date: _____________________
Parent/Guardian Signature (as appropriate)

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The Law requires that I obtain your signature acknowledging that I have provided you with the following information:

COLORADO NOTICE FORM: Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

By signing below, I acknowledge that I have received from Rachel Bédard, Ph.D. the information listed above. I also understand that it is very important that I read this information carefully before our next session. I understand that I can discuss any questions I have about the procedures at that time.

____ Date: _____________________

Signature of Client or Responsible Party

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General Practice Information

Fees

Fees vary depending on services provided. The fee for each 45-minute therapy or consultation session is $______. Payment is due at the beginning of each session unless other arrangements are made. Fees for court related services are available upon request.

Insurance

Several insurance companies will cover at least a portion of the cost of psychological services. However, you (not your insurance company) will be responsible for full payment of my fees. If you wish to seek reimbursement through eligible insurance coverage, I will assist with this process by providing any documentation that may be needed.

Cancellation Policy

Please realize that you have a reserved therapy or consultation time. To avoid being billed for your scheduled session, please notify me at least 24 hours in advance of any appointments which cannot be kept. Late cancellations (less than 24 hours) will be charged the full therapy fee. You will *not* be charged if you cancel due to illness or poor weather. Thank you!

Email/Texting

Email and texting are not considered confidential. Please limit texting and email to scheduling needs. Please do not share personal information via text or email. I cannot guarantee confidentiality if you do choose to share personal information via email or text.

Accounts Past Due

You are expected to keep your account current. I reserve the right to forward your name to a collection agency when payment is seriously delinquent and no agreement has been made with me regarding payment.

Emergency Services

I do not provide emergency or after hours services. If during the course of services provided an emergency situation arises, you are encouraged to access the appropriate community services or call 911.

Please discuss any questions you may have about the above procedures with me.

By signing below, I agree to the arrangements outlined above and I have been given a copy of this form.

____ Date: _______________________
Signature of Client or Responsible Party

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Authorization to Release/Request Information

____   ________________

Client's First   Middle   Last Names   Client's Date of Birth

Hereby authorizes Dr. Bédard to **exchange information with and collect information from**:

Name of Person, School, Hospital, Agency:
____

Street Address:____

Phone Number: ____

The above information will be used for the following purpose(s):

( ) Planning Appropriate Treatment or Program   ( ) Case Review

( ) Continuing Appropriate Treatment or Program   ( ) Updating Files

( ) Determining Eligibility for Benefits or Program   ( ) Other (specify) _______________

Such information is considered confidential and is to be used in the best interest of the above named person. Information may be shared via telephone, facsimile, mail or in person.

I understand and voluntarily agree to authorize the exchange of information. I understand my consent can be revoked at any time and will expire in one year from the date of my signature. I understand that this consent may include disclose of alcohol and drug abuse records protected by federal regulation.

____   ____________

Signature of Client or Responsible Party   Date