



**JUDITH BRODIE, MA, LPC, LLC**

*Counseling and Psychotherapy Services*

3939 E. Arapahoe Rd.  
Suite 215  
Centennial, CO 80122  
303.503.5282

**DISCLOSURE AND PRACTICE POLICIES STATEMENT AND CONSENT**

Qualification/Experience

I am pleased you have selected me as your counselor. This document is designed to inform you about my background and to insure that you understand our professional relationship.

I have an M.A. in Counseling Psychology from Regis University and a B.A. from the University of Colorado. I am licensed in the State of Colorado as a Professional Counselor.

The Colorado Department of Regulatory Agencies has the responsibility for regulating my practices. The specific agency with the responsibility for both licensed and unlicensed persons in the field of psychotherapy is the State Grievance Board, 1560 Broadway, Suite 1370, Denver, CO 80202, 303-894-7766.

Client Information

At any time you may ask about my methods of therapy, the techniques I use, the duration of your therapy, if I can determine it, and the fee. You may always seek a second opinion from another therapist or terminate therapy at any time. Also, if I feel that I am unable to assist you adequately, I reserve the right to suggest a referral option. In a professional relationship, sexual intimacy between a therapist and a client is never appropriate.

Confidentiality

Information provided by and to a client during therapy sessions is legally confidential and cannot be disclosed without your consent. You should know, however, that it is the law and my policy only to accept clients who waive confidentiality under the following circumstances:

- If there is suspicion of child or elder abuse or neglect,
- if I determine that you are a danger to yourself or to others,
- if you provide written consent to release information, or
- if a court of law issues a legitimate subpoena or if you are involved in criminal proceedings.

Fees, Cancellation and Insurance Reimbursement

My full fee for services is \$110.00 per fifty-minute session or \$165.00 per 75 minute session. Your fee is \$\_\_\_\_, per \_\_\_\_ minute session. Unless other arrangements have been made, you are responsible for full payment of the above agreed upon fee at the time of each session. Cash or personal checks are acceptable for payment.

When we arrange a session, my time has been scheduled specifically for you. Therefore, I will charge you our agreed upon fee (noted above) for cancellations made less than 24 hours prior to arranged appointment times (excluding cases of genuine emergency). I will be happy to accommodate you if there is another appointment time that works for you.

Insurance Coverage

If you would like to use insurance coverage, I request that you pay me in full at the time of your sessions and I will supply you with a receipt that you may submit to your insurance company. You are responsible for determining if my services are covered under your particular insurance plan.

Telephone Calls and Telephone Sessions

If you need to speak with me between sessions, I will be glad to return your calls. I do not carry a pager, but I check my messages frequently throughout the day and usually return calls within a few hours. It's important for you to note that unless other arrangements have been made, I charge for telephone conversations lasting longer than 10 minutes. In case of an emergency, you should call 911 or go to the nearest hospital emergency room.

On occasions, if meeting with you in person is not possible, I will be happy to arrange a telephone session with you. My fee for phone sessions is the same as our regular agreed upon fee.

Consultation

It is standard practice and of benefit to you as a client for the psychotherapist you work with to do clinical consultation with other professionals. I do consult with Licensed Mental Health Professionals regarding my caseload, from time to time, for the purposes of accurate and appropriate treatment and overall quality of care. Confidentiality applies to these consultations and I do not provide names or other identifying information unless I obtain a release from you.

If you have any questions at any time or would like additional information, feel free to ask. Please note that any additions or exceptions to these policies will be indicated as an attachment.

By your signature below (please sign both copies, keep one for your files and return the other copy to me), you are indicating that you have read and understood the preceding information, understand your rights as a client, and agree to participate in treatment within the guidelines set forth here.

Adolescent Addendum

If your child is in treatment with me and is between the ages of 15 and 18, by your signature below, you agree that I may determine what information, in my professional judgement, is appropriate to be shared with you, the parent or guardian, concerning treatment issues, and what information, in my discretion, will remain confidential between the the adolescent and myself.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Judith Brodie, MA, LPC, LLC

\_\_\_\_\_  
Date