



## *COUNSELING SOLUTIONS LLC*

Elizabeth J. Pickreign, MA, LPC  
10465 Melody Dr., Suite 215  
Northglenn, CO 80234  
www.counselingsolutionsco.com  
(720) 583-8199 [counselingsolutionsco@gmail.com](mailto:counselingsolutionsco@gmail.com)

### **Informed Consent Adolescent**

Therapy can be scary and confusing. Meeting with a counselor can help you with struggles which may be impacting school, home, friendships, and/or how you feel about yourself and help you feel more successful in these areas of your life. You may have asked to speak with a counselor or you were brought in because your parents, family, teachers, and/or doctor are concerned about you. Counseling can help you understand yourself more, understand your struggles, and building new ways of coping and addressing situations in your life.

Information in this form is for you and for your parent(s)/guardian(s). Part of this process includes your participation as an active member of the therapeutic relationship. Another part is how comfortable you feel working with me as your counselor. Therapy has positives and negatives for you as a client. This may include addressing those struggles or negative situations which bring about unwanted, uncomfortable, and negative feelings. It also can bring about growth and positive change. While there are no guarantees to the outcome of therapy, I believe that therapy can be beneficial.

#### **My Training and Approach to Therapy**

I have a Masters of Arts in Professional Counseling which I earned in 2008 from McKendree University in Lebanon, IL. I am a Licensed Professional Counselor (LPC) in the state of Colorado (#6483). As stated by the regulatory requirements for mental health providers, Licensed Professional Counselors must hold a Master's degree in their profession and two years post-master's supervision.

My areas of experience include adults and adolescents both in residential and outpatient settings and addressing varying issues including depression, anxiety, personal growth, trauma, abuse, and people recovering from alcohol and drug addictions. I also have experience helping couples navigate struggles with their relationships.

Your first 2-3 sessions will include getting to know you and what may help you in therapy as well as what your goals are for counseling. A treatment plan based upon your needs and goals will be developed after the first session has been completed. My approach to therapy varies across several therapeutic approaches including Cognitive-Behavioral Therapy (CBT), Dialectical-Behavior Therapy (DBT), Reality Therapy, and Person-Centered Therapy. I focus on the control of the individual to make change and manage their behaviors and feelings effectively. I also work to provide a safe, supportive, and environment where we work together to address your treatment issues and goals. Some techniques I use include talking, coming up with alternative thoughts, relaxation techniques, mindfulness skill building, homework outside of therapy, and reading books. If a technique poses a potential risk, I will inform you of the potential risks of the technique prior to implementing any technique. If medical information is needed for therapy purposes, I may speak with you and/or your parents about seeing a doctor and I, also, would need a written consent to communicate with your doctor. You have the right to refuse anything I suggest in

treatment. If you have any questions regarding my techniques or counseling approaches, do not hesitate to ask me questions as I will answer your questions to the best of my ability.

## **Confidentiality**

Confidentiality is the protection of information that is discussed in counseling remains between you and me and follows the guidelines of the Notice of Privacy Practices (attached). It can create anxiety if you are concerned that information you talk about in counseling will get back to your parents, teachers, or other adults in your life. As a teenager, you have certain rights to privacy that are different from an adult (the legal definition of which is 18 years old), but confidentiality is an important part of counseling. Things you share with me in session is confidential, unless you give me written consent to talk about certain information. I request that an emergency contact be given strictly for emergency purposes; however, I will not speak with this person without written consent and an emergency arises. You may give consent for me to share information with anyone that you choose as well as revoke that consent, in writing, at any time.

There are exceptions to confidentiality that are important to understand before starting the counseling process. In some situations, law and/or professional guidelines require me to share information discussed in therapy. These situations are outlined below. Most are for your protection and the protection of others from the potential to be hurt or harmed.

Limitations to confidentiality are as follows:

1. You are a danger to yourself. If I feel that you are at risk of harming yourself, I may legally break confidentiality and call 911 or a crisis team to ensure your safety. I would explore all options including creating a safety plan with you prior to taking this action, but if you are unwilling to take steps to guarantee your safety, I will call 911 or a crisis team.
2. You are a danger to someone else. If I have good reason to believe that you will harm another person, I must attempt to inform that person and your intentions. I must also contact the police and ask them to protect your intended victim.
3. If you are involved in activities that could cause harm to yourself or someone else. Even if you do not intend to harm someone else or yourself, based upon evaluation of this behavior, confidentiality can be broken.
4. If you report that you are being abused or have been abuse – physically, emotionally, or sexually, the law requires that this information be reported to the authorities.
5. If you are involved in a court case and a request is made for information about your counseling sessions, this information will be disclosed with your written consent unless the court requires information be provided with a court order. If this happens, you will be informed of this information and the next steps. Efforts to protect your confidentiality will be taken and discussed with you as well.
6. If you agree that information can be shared with a specific person or entity, I will need written consent and we will discuss what information is shared and how it will be shared.

Except for these limitations, your parent(s)/guardian(s) will not be told specific information you share in therapy. There may be times where it is important to involve your parents in counseling or to let your parents know some information which is confidential and I may encourage you to include them or share this information with them. Part of my job is to discuss this with you and decide together how to communicate this information.

A limit to confidentiality that is not a legal exception is the use of technology for communication purposes. We communicate through many different means including phone calls, email, and text messaging. It is important to inform you that these methods of communication are not completely confidential and to be used with caution regarding information you seek to share through these methods.

I may consult with other mental health professionals if I determine that consulting will provide best care for your treatment. I will make every effort possible to disguise identifying information when consulting with other

professionals to ensure confidentiality. In the event that I am not able to disguise your identifying information, I will obtain your written consent to consult with another professional prior to the consultation. Consultation with any other professionals including medical, employment, and/or education requires written consent before I will consult with any of these professionals.

Parents and guardians may be able to be helpful if they have general ideas about therapy including status of symptoms, achievements in counseling, and the therapist may have ideas for your parent(s)/guardians which may not break privacy or confidentiality. I strongly encourage parents to respect the privacy of your counseling and the process.

Information will not be shared with your school or any school professionals including coaches or extracurricular activity teachers, including that you are even seeing a therapist, unless you and your parents/guardians give permission. If someone from school wishes to speak with me regarding your treatment, or if talking with the school is in to your benefit, then you and your parents will be asked to give written permission prior to any discussion with school officials. If your parents or school want information about the treatment, and you do not want to give permission, this will be discussed a session.

Your medical doctor may have referred you for therapy or medications are involved either through existing prescriptions or exploring the idea of medication. It may be important to work with your doctor or doctor's office regarding your progress or status in counseling, especially when medication is involved or there are other health issues. As with school, your permission will be required for communication to occur and it will be important to discuss in therapy what information will be shared, especially since some information can be shared with a doctor that is not shared with your parents. The only time information can be shared with your medical doctor without your permission is if you are engaged in harmful or risky behavior that creates a concern about safety.

### **Insurance**

As a teenager, you are not financially responsible for your therapy. This section is more for you parents, but may also be helpful for you to understand as part of your treatment and information disclosed to insurance companies. Insurance provides benefits and risks that you should be aware of when using your insurance to cover your mental health costs. The benefit of using insurance to pay for your therapy is that it can be more financially possible to get the help you want and need. However, using your insurance also affects confidentiality and your information. Most insurance companies require that I provide a clinical diagnosis for services provided. A clinical diagnosis is a medical code/label that describes the nature of your participation in therapy and is determined by a book entitled the DSM-5. I have a copy in my office if you would like to learn more about your diagnosis. At times, additional clinical information may be required such as treatment plans, summaries of progress, or possibly a copy of your entire file. While insurance companies state that they keep this information confidential, I have no control over the information once they have this information.

It is important to be aware if your insurance requires advanced authorization for services and may refuse to pay for mental health services if this is not obtained. It is also important to understand that insurance companies may dictate length of services they are willing to cover and if they will accept claims from an out of network provider. There are other limitations to using insurance where you may have a co-payment for your sessions or you may have to meet your deductible before your insurance company will cover therapy fees. If you owe for your deductible, claims may still be made to your insurance company so that your session costs are applied to your deductible. You always have the right to pay for my services yourself to avoid these stated situations.

If I am not a participating provider for your insurance plan, I will provide you with a receipt of payment for services and you can submit this to your insurance company for reimbursement. Please note that not all insurance companies will reimburse for out of network providers. If you would prefer to use a participating provider, I can help you find someone on your provider list to refer you to. If you choose to not use your insurance, you will be responsible for the full fee of therapy services.

Revised 08/02/2018

I currently accept Mines & Associates EAP, ComPsych EAP, Cigna, Beacon Commercial Insurance, PHCS/Multiplan, and United Healthcare.

If you have further questions about using your insurance or about your insurance coverage, you can call your insurance company to obtain information.

### **Appointments, Payment, & Professional Fees**

#### **Appointments:**

- \* The standard fee is \$120.00 per appointment and appointment times are usually 45-50 minutes in duration. Payment is expected at the time of your session unless other arrangements have been made prior to your appointment.
- \* Frequency of appointments may vary based upon needs or availability.

#### **Payments:**

- \* Payment of co-pay or client responsibility is due at the time of service. By signing this consent for treatment, you are agreeing to pay required co-pays, amount due indicated through insurance benefits, or self-pay amount due for each session.
- \* Payments can be made using cash, credit card, or check.
- \* If you pay using a check and the check is returned, you are responsible for a \$25.00 fee in addition to the cost of your session. You will no longer be able to pay with a check if two checks are returned.
- \* Currently, I do not require a credit card on file for other insurances or cash payment. I will inform you if this changes in the future.
- \* See the Attendance Policy for Missed/Late Cancelled appointments.

#### **Professional Fees:**

In addition to scheduled appointments, it is my practice to charge this amount on a prorated basis for other professional services that you may require such as:

- \* treatment summary reports
- \* telephone conversations lasting longer than 15 minutes
- \* attendance at meetings or consultations which you have asked me to attend.

If you anticipate becoming involved in a court case, I recommend that we discuss this prior to you waiving your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

### **Termination of the Therapeutic Relationship**

In most situations, you will be the one to decide when therapy ends. There are some exceptions to this including if I do not feel, in my judgement, able to help you either because of your specific issue or my training and skills are not appropriate and if you demonstrate aggressive behaviors that are threatening, verbally or physically abusive, or harass myself, the office, staff, or my family. In the situation where therapy may be terminated due to my skills not matching your needs, I will discuss the situation with you and refer you to another mental health professional that may be a better fit. If you become aggressive or violent, I reserve the right to terminate therapy immediately and referral will also be made for other resources of care. It is not guaranteed that the referrals will accept you for therapy.

If you cancel or miss an appointment without rescheduling, I will attempt to follow up with you to reschedule. If I am unable to reach you and/or do not hear from you for 30 days, your file will be closed. You are welcome to return to therapy at any time, but I am unable to keep files open indefinitely.

## **Professional Records**

I am required to keep appropriate records of the services I provide. This includes intake documents, treatment plans, releases of information, progress notes, and insurance/billing records. Your records are maintained through an electronic health record software, Practice Fusion. This is a HIPAA compliant online program designed to maintain client charts. You have the right to access your file and review, however, I do not allow access to progress notes because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I encourage you to initially review them with me or have them forwarded to another mental health professional to discuss your file. You have the right to request that any other health care provider may have a copy of your file by providing written consent to me.

I am required to keep your records for 7 years after the end of treatment either by termination or inactive communication. For minors, I am required to keep records for 7 years after the end of treatment or upon the minor turning 18; whichever one comes later and no more than 12 years.

## **Contacting Me**

I am not always available immediately by phone or email. I do not answer my phone or respond to emails while in sessions with other clients or otherwise unavailable. You are welcome to leave me a message on my confidential voicemail or email me and I will respond within 24-48 business hours. Please remember that information through cell phones, texting, or email is not completely confidential as covered in the Confidentiality section of this agreement.

If you are unable to reach me and feel that you cannot wait for a return phone call or if you feel unable to keep yourself safe:

- 1.) Call 911
- 2.) Go to your local hospital emergency room
- 3.) Contact Rocky Mountain Crisis Partners at (844) 493-8255

I will communicate with you if I will be out of the office for planned vacations or absences and I will provide you with the name and contact information of a mental health professional covering my practice during my absence.

## **Social Media**

Many of us have social media pages including Facebook, Instagram, Twitter, etc and this section outlines my policies regarding use of these sites. I have a business Facebook page and an Instagram account which can be found through my website. I do not accept friend requests or approve fan requests from current or former clients as this may compromise confidentiality and our respective privacy. This also impacts professional boundaries and our working relationship. If you have questions regarding this, please do not hesitate to ask and we can have a discussion where I can answer any questions.

## **Other Rights**

If you are unhappy or uncomfortable about what is happening in therapy, I hope that you will talk with me so that I may respond to your concerns. I value your feedback and take your concerns seriously. If you feel that you are not able to address your concerns with me directly, that I have not taken you seriously, or that I have behaved unethically, you can make a complaint with:

Department of Regulatory Agencies (DORA)  
1560 Broadway, Suite 110  
Denver, CO 80202  
(303) 894-7855

You may request that I refer you to another mental health professional and are free to end therapy at any time. You have the right to respectful and safe care without discrimination of race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask me further questions about my training, experience, and practices of therapy. You have the right to expect that I will not have social or sexual relationship with clients or former clients.

**Consent to Therapy**

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

\_\_\_\_\_  
Client Name (Printed)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (Printed)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (Printed)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor Name (Printed)

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date



## COUNSELING SOLUTIONS LLC

Elizabeth J. Pickreign, MA, LPC  
10465 Melody Dr., Suite 215  
Northglenn, CO 80234  
www.counselingsolutionsco.com  
(720) 583-8199 counselingolutionsco@gmail.com

### Attendance Policy

As stated in the Informed Consent form, the therapeutic process includes your consistent attendance and participation in your therapy sessions to get the maximum benefit of therapy. Below you will find information regarding the importance of attendance and participation for your sessions and responsibilities.

Here is information to consider regarding missed or late canceled appointments:

- \* Please note that your appointment time is scheduled for you and you alone. Your time is valuable as is the time of the counselor.
- \* The Attendance Policy Fee for missing or canceling an appointment late is **\$50.00**
- \* A Late Canceled appointment refers to canceling your appointment **less than 24-hours** before your appointment time.
- \* A Missed appointment refers to being more than 15 minutes late and/or not showing for your appointment at all without communication.
- \* Insurance **DOES NOT** reimburse for missed or canceled appointments and would be considered insurance fraud if an appointment was billed for without the service being provided.

Client Responsibilities:

- \* You are responsible for attending your appointment on time. I allow a 15-minute window regarding this responsibility as I understand traffic and life events can create time constraints. Being more than 15 minutes late impacts the therapeutic process of your session. If you are more than 15 minutes late, your appointment will be considered a missed appointment and you will be charged the attendance policy fee.  
**Initial:** \_\_\_\_\_
- \* You are responsible for notifying the counselor of needing to reschedule or cancel your appointment **24 hours or more** prior to your scheduled appointment time. If you do not give 24 hours or more, you will be charged the Attendance Policy Fee. There are occasions where circumstances are beyond your control and an exception may be made in this case. Examples: Family Death, Sudden Illness, Hospitalization, etc.  
**Initial:** \_\_\_\_\_
- \* You are responsible for payment of your missed/late canceled appointment at the time of your next scheduled appointment. If you cancel late or miss an appointment because you decide not to continue in counseling, you will be sent an invoice for the late cancel or missed appointment.  
**Initial:** \_\_\_\_\_

Counselor Responsibilities:

- \* Counselor will attempt to follow up with client within a week of a missed appointment and/or if the client does not reschedule when canceling an appointment.
- \* Counselor will attempt to provide an appointment time within the same week given the counselor's availability.
- \* Counselor is responsible for discussing scheduled times out of the office with the client and providing appointment times around the time out of the office or referring the client to another counselor for the interim until the counselor returns to the office.
- \* Counselor will notify the client immediately if the counselor is ill and will be out of the office. The Attendance Policy Fee does not apply to the client in this situation.

Revised 08/02/2018

**Inclement Weather Policy**

Weather can be unpredictable and hazardous especially in the winter. If the client does not feel safe driving during inclement weather, they may cancel/reschedule their appointment without penalty of the Attendance Policy and the associated fee. If the counselor decides to close the office due to inclement weather, the counselor will notify the client via phone, email, or text regarding the decision and make attempts to reschedule the client. The Attendance Policy Fee also does not apply to the client in this situation.

By signing this policy, you agree that you understand the Attendance Policy as it is written and that you will be held accountable to the above responsibilities.

_____	_____	_____
Client Name (Printed)	Client Signature	Date
_____	_____	_____
Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date
_____	_____	_____
Counselor Name (Printed)	Counselor Signature	Date



# COUNSELING SOLUTIONS LLC

Elizabeth J. Pickreign, MA, LPC  
10465 Melody Dr., Suite 215  
Northglenn, CO 80234  
www.counselingsolutionsco.com  
(720) 583-8199 counselingolutionsco@gmail.com

## Acknowledgement: Receipt of Notice of Privacy Practices

I have received a copy of Counseling Solutions, LLC Notice of Privacy Practices effective May 1, 2017.

Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I am a parent or legal guardian of \_\_\_\_\_ (client name). I have received a copy of Counseling Solutions, LLC Notice of Privacy Practices effective May 1, 2017.

Name (Please Print): \_\_\_\_\_ Relationship to Client:  
 Parent  Legal Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the individual or parent/guardian did not sign above, Counseling Solutions, LLC must document when and how the Notice of Privacy Practices was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective May 1, 2017 were given to \_\_\_\_\_ on \_\_\_\_\_  
 In Person  Mailing  Email  Other: \_\_\_\_\_.

Reason individual or parent/guardian did not sign this form:

- Did not want to
- Did not respond after more than one attempt
- Other: \_\_\_\_\_

The following good faith efforts were made to obtain the individual or parent/guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

- In Person Conversation: \_\_\_\_\_
- Telephone Contact: \_\_\_\_\_
- Mailing: \_\_\_\_\_
- Email: \_\_\_\_\_
- Other: \_\_\_\_\_

Counselor Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_