Insight Psychology, LLC

DISCLOSURE STATEMENT & CONSENT TO TREATMENT

Information:

Crystal Wildes
4611 Plettner Lane Ste. 100
Evergreen, CO
720.443.3112

455 Sherman St. Ste. 140
Denver, CO 80203
720.443.3112

Credentials:

Degrees-

- Doctor of Psychology- Clinical Psychology Illinois School of Professional Psychology, 2012
- Master of Arts- Clinical Psychology Illinois School of Professional Psychology, 2011
- Master of Science- Community Counseling Drake University, 2007
- Bachelor of Science- Psychology Major, Sociology Minor Iowa State University, 2002

Licensure-

- Licensed Psychologist (LP)- Colorado PSY.0004027

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 Department of Regulatory Agencies, Psychologist Examiners Board can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, 303.894.7800. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

Client Rights & Important Information:

- You are entitled to receive information from me about my methods of therapy, the techniques I use, and the duration of your therapy, and my fee. Please ask if you would like to receive this information.
- You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Board that licenses, certifies, or registers the therapist.
- Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement and/or the Department of Human Services; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental

disorder; (4) I am required to report any suspected threat to national security to federal officials; and (5) I may be required by Court Order to disclose treatment information.

- When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and Consent to Treatment and agreeing to treatment with me, you consent to this practice, if it should become necessary.
- Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.
- I agree not to record our sessions without your written consent; and you agree not to record a session or a conversation with me without my written consent.

Disclosure Regarding Divorce & Custody Litigation:
If you are involved in a divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement & Consent to Treatment, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

Financial Agreement:
By entering into a professional psychotherapy relationship with Dr. Wildes/Insight Psychology, LLC, you are also entering into a financial arrangement. Payment for services rendered is the sole responsibility of the client (or responsible party as signed below), unless otherwise agreed upon in writing by Dr. Wildes/Insight Psychology, LLC and the client(s). Unless otherwise arranged, psychotherapy sessions will be conducted face-to-face and will last 45-50 minutes. The standard fee per session is $150 and will be due at the time of service. Any other fee must be agreed upon via a written Fee Adjustment Agreement. Sessions lasting over 50 minutes in length may be subject to additional service fees.

Cancellation Policy:
Twenty-four hour notice via phone is required for cancellations. Any schedule changes or cancellations received less than 24 hours in advance may be charged the standard fee. Any missed appointment without notice will be charged the standard service fee as agreed upon in this disclosure.

Insurance:
Dr. Wildes/Insight Psychology, LLC does not directly bill insurance. Upon request Health Insurance Claim Forms will be provided for out-of-network reimbursement requests.

Policy for Non-Payment/Collection Agency: In the event billing efforts fail, delinquent accounts may be subject to collections. Dr. Wildes/Insight Psychology, LLC will attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending a balance to collections.

Consent to Treatment:
I have read the preceding information, and it has been presented to me verbally. I understand disclosures that have been made to me as well as my rights as a client to mental health and/or consultation services with Crystal Wildes, Psy.D., LP in accordance with the information contained within.

I acknowledge that I have received a copy of this Disclosure Statement & Consent to Treatment.

_____
Print Client's Name

_____ _____
Client Signature or Responsible Party Date

_____
Relationship of Responsible Party

_____ _____
Witness Date

Receipt of Notice of Privacy Rights
I acknowledge that at the time of receiving and signing this form, I have also received the Notice of Privacy Rights of Insight Psychology, LLC.

_____ _____
Client Signature or Responsible Party Date

_____
Relationship of Responsible Party

_____ _____
Witness Date