Authentic Life Christian Counseling
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DISCLOSURE STATEMENT & POLICIES

As a counselor, it is a privilege to journey with people as they face the various challenges of life. It is my desire to walk alongside people in the struggles they face or the traumas they need to overcome. In my practice, I use sound Biblical principles, advanced Brainspotting, CBT, and EFT to help people in this journey. It is my hope that this work will allow people to live a more authentic life.

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. Authentic Life Christian Counseling ("ALCC") is located at 7220 W. Jefferson Ave Suite 202, Lakewood, Colorado, 80235, 720-257-9515. The mental health professional located at ALCC is Vicki Faris, LPC. Vicki Faris received her Bachelor of Science degree in Psychology and Bachelor of Arts degree in Speech Communication from Colorado State University in 1998. She completed her Master of Arts degree in Counseling Psychology and Counselor Education from the University of Colorado, Denver, in 2003. Vicki Faris is a Licensed Professional Counselor in the State of Colorado, License Number, 4915. She is certified as a National Certified Counselor and Approved Clinical Supervisor with the National Board of Certified Counselors (NBCC) and is a certified Brainspotting Practitioner. Finally, Vicki Faris is a trained PREPARE/ENRICH facilitator. Additional education, training, and experience is available upon request at any time.

2. Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old. A parent or legal guardian with the authority to consent to mental health services for a minor child/ren in their custody must also sign this disclosure statement on behalf of their minor child over the age of twelve (12) but under the age of fifteen (15) years old, unless said minor is voluntarily seeking psychotherapeutic services for themselves without their parent's or legal guardian's knowledge or consent. In this case, the minor who is between the age of twelve (12) and fourteen (14) years old, in addition to this disclosure statement, shall also sign a Voluntary Consent for Psychotherapeutic Services form.

The mental health professional providing services to a minor between the age of twelve (12) and fourteen (14) may advise the minor's parent or legal guardian of services provided with the consent of the minor or a court in specific circumstances, unless notifying the parent or legal guardian would be inappropriate or detrimental to the minor's care and treatment. The mental health professional may notify the parent or legal guardian, without the minor's

consent, if

in their professional opinion the minor is unable to manage their own care or treatment, or if the minor expresses any suicidal ideation.

In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is ALCC's policy to seek the consent of both parents/legal guardians, however this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination and this is the governing policy unless the child's health, safety, and welfare could be at risk. If this is the case, you must inform the ALCC so that appropriate action for the protection and welfare of the child may be taken. This disclosure statement contains the policies and procedures of ALCC and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

3. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through ALCC's internal process.

4. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.

5. Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Unlicensed Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

Certified Addiction Technicians must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or equivalent, and complete 1,000 hours of supervised experience. Certified Addiction Specialists must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselors must have a clinical master's degree, pass the Master Addiction Counselor Exam, and complete 3,000 of supervised experience. Licensed Social Workers must hold a master's 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 Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in his or her 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. An Unlicensed Psychotherapist is a psychotherapist listed in Colorado's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. Unlicensed Psychotherapists are required to take the jurisprudence exam.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

As a client you are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, if I can determine it, and my fee structure. Please ask if you would like to receive this information.

Fees:

1. My fee structure, services, and fee policy are outlined as follows:

a. Individual Therapy: $130.00 per hour
Individual Therapy (extended session): $150.00 per 75-80min
Conjoint Therapy: $140.00 per hour
Conjoint Therapy (extended session): $175.00 per 75-80min

b. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

c. Therapy fees and treatment are based on a 45–50-minute clinical hour instead of a 60 minute clock hour so that I may review my notes and assessments on your behalf.

d. I **am not** a Medicaid provider. If you have or obtain Medicaid coverage that includes mental health services, I **am not** able to offer mental health services to you.

e. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $375.00 per hour.

Restrictions on Uses:
2. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however ALCC is not required to agree to a restriction request. Please review ALCC's Notice of Privacy Policies for more information.

Second Opinion and Termination:
3. You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

Sexual Intimacy:
4. In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Licensed Professional Counselor Examiners

Confidentiality:
5. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Certified and Licensed Addiction Counselor, or an Unlicensed Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

6. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-245-220. You should be aware that provisions concerning disclosure of confidential

communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S. § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out ALCC's Consent for Communication of Protected Health Information by Unsecure Transmissions.

"No Secrets" Policy:
7. When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e. on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless I am required to do so by law. However, in the event that you disclose information that is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. As your therapist, I will use my sole discretion and best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, I will first give the individual the opportunity to make the disclosure to the other party themselves. This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

"No Secrets" in Custody Circumstances Policy:
8. When treating a Client who is a Minor under the age of fifteen (15) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email (i.e. all communication will "cc" both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, I reserve the right, in my sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, I will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or regulations regarding the protection of the health, safety, and welfare of the child/ren.

This policy will also be extended to clients who are over the age of twelve (12) but under the age of fifteen (15) when and if their parents or legal guardians are notified of their receiving psychotherapeutic services.

Extraordinary Events:
9. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: _Marcia Pritchard, LPC _____
TEL: (303) 332-4825_____
CREDENTIALS: __Licensed Professional Counselor, License No. LPC.00005850

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Maintenance of Client Records:
10. As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of License Professional Counselor Examiners, ALCC will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. If the client is a minor, the record shall be retained for a period of seven years commencing either upon the last day of treatment or when the minor reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years. ALCC cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records:
11. ALCC may keep and store client information electronically on ALCC's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, ALCC may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. ALCC may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

ALCC may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. ALCC uses a cloud-based service for storing or backing up information. The cloud-based backup system ALCC uses is TherapyNotes and the email service provider ALCC uses is Zoho Mail. ALCC may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information ALCC has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures ALCC employs, please ask.

Availability and Response Policy:
12. My normal business hours are Monday-Friday, 9:00am – 6:00pm, however, as a therapist, the majority of my business hours are devoted to seeing my clients in therapy, which means I am not always available for immediate contact via phone, text, or email. **This is especially true for emergencies, as I am not equipped to respond immediately.**

The best way to contact me is via (phone/email). Every effort will be made to respond to you in a clear and timely manner. Voicemails and texts sent to 720-257-9515 will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. Emails sent to vicki@alccounseling.com will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. It is my policy to return all phone calls, texts, and emails during my normal business hours

(referenced above). I also reserve the right, in my sole discretion, to return communication outside of these hours; but any communication which I initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of my normal business hours.

Additional Treatment Modalities:
13. I may offer to employ additional treatment modalities and therapeutic methods that I deem to be the most beneficial to your treatment. These modalities may include but are not limited to: Brainspotting. I am trained and qualified to provide this additional treatment method and I will/may ask you to sign an additional consent form, specific to each modality, prior to implementing them in your treatment. As the client, you always retain the right to consent to incorporating these modalities into your treatment and you may retract your consent at any point in time.

Spiritual Counseling:
14. As a Christian Counselor, faith is an important component within counseling, and I strive to honor your faith and beliefs in the process. In addition to using psychological approaches and methodology, I may from time to time offer to incorporate passages of scripture, prayer, or other spiritual disciplines into my work. You retain the right to decline the integration of spiritualty and psychotherapy and this does not prohibit our ability to work together in a traditional psychotherapy capacity.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that ALCC may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with ALCC ‘s Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in ALCC’s Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.

3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my therapist.

4. I understand that ALCC does provide Teletherapy, such as therapy over telephone or video platform. If both therapist and client agree to engage in Teletherapy as a treatment modality, I may be asked to complete an additional consent form, and that I agree to utilize a secure and HIPAA compliant means for communication to ensure confidentiality and the protection of private information.

5. I understand that my therapist, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that ALCC has, or may have, a business social media account page. I understand that there is no requirement that I “like” or “follow” this page. I understand that should I “like” or choose to “follow” ALCC’s business social media page that others will see my name associated with “liking” or “following” that page. I understand that this applies to any comments that I post on ALCC’s page as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and **not** through social media.

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

7. I understand my therapist provides non-emergency therapeutic services **by scheduled appointment only**. If, for

any reason, I am unable to contact my therapist by the telephone number provided to me, 720-257-9515, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. ALCC does not provide after-hours service without an appointment. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due**. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call within 48 hours, excluding holidays and weekends.

8. If my therapist believes my therapeutic issues are above her level of competence or outside of her scope of practice, my therapist is legally required to refer, terminate, or consult.

9. **I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance company receives the information I or my therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report ALCC submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.**

10. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

11. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement, I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to **sign a separate Consent for Third-Party Participation Agreement** or may have to sign a separate disclosure statement in order to participate in therapy.

12. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with ALCC or my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with ALCC. Ability to resume therapy after sixty (60) days will depend upon my therapist's availability and will be within her sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least sixty (60) days, unless otherwise agreed to in writing.

13. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

14. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to her

relatives, friends, the relatives of friends, people known socially, or business contacts.

15. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.

16. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services here at ALCC. In the event that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15) and for whom I am requesting therapy services here at ALCC, I understand it is ALCC's policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren's treatment in accordance with DORA policy.

If I am the non-custodial parent signing this consent form for my minor child/ren's treatment in accordance with DORA's policy, I understand that my access to my child/ren's treatment and client record may be limited by court order.

In the event that I am over the age of twelve (12) but under the age of fifteen (15) years old, I affirm that I am consenting to treatment and psychotherapeutic services here at ALCC, and that I have been advised by Vicki Faris, LPC, of the importance of involving my parents and/or legal guardians, and that I have willingly signed the Voluntary Consent for Psychotherapeutic Services form.

17. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with ALCC, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. I also understand that it is ALCC's policy to request and seek consent from both my minor child/ren's parents, but that such consent does not supersede the Court Order Custody Agreement and/or Parenting Plan. By signing this form, I understand and consent to ALCC 's "No Secrets" in Custody Circumstances Policy as outlined above. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

18. By signing this form, I affirm that I am fully informed of the therapy services I am requesting and that ALCC is providing and grant my consent to receive such therapy services.

My signature on the final page affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

Signature Page

_____ _____

Client Name/Signature DATE

_____ _____

Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

_____ _____

Parent/Legal Guardian Signature (Please specify Relationship to Client) DATE

Vicki Faris, LPC, Signature DATE