



**Dr. Brenna Tindall, Psy.D., CAC III**  
**Arête Counseling Services, LLC**  
**506A S. College Avenue**  
**Fort Collins, Colorado 80524**  
**(970) 231-9611**

## **Disclosure Statement**

### **Service Provider:**

Brenna Tindall, Psy.D., CAC III

### **Education/Degrees:**

Doctorate in Clinical Psychology  
University of Denver, 2009

Masters of Arts, Clinical Psychology  
University of Denver, 2007

Bachelor of Arts, Psychology  
Colorado State University, 2001

### **Registrations:**

Certified Addiction Counselor III, License #: 6898, Exp 08/31/2011  
Associate Level Provider, Sex Offender Management Board  
Unlicensed Psychotherapy Board, Department of Regulatory Agencies  
Number: 11222, Expires 8/31/2011. Dr. Tindall is also being supervised by Licensed Psychologist, Rick May, Psy.D (License #:1964).

Department of Regulatory Agencies:

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addition counselors, and unlicensed individuals who practice psychotherapy. The agency within the Department that has the responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulator Agencies, Mental Health Section. Their contact information is detailed below:

Department of Regulatory Agencies  
Mental Health Section  
1560 Broadway, Suite 1350  
Denver, Colorado 80202  
(303) 894-7766

### **Client Rights and Important Information:**

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 that), and my fee structure. 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 Department of Regulatory Agencies, Mental Health Section.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified additional counselor, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. There are exceptions that I will identify to you as the situations arise during therapy.

The information provided by the client during therapy is confidential except for certain legal exceptions. Exceptions to the rule of confidentiality will be identified to you should any such situation arise during therapy. Examples of such exceptions include but are not limited to: a client who is an imminent danger to self or others; there is suspected child abuse or neglect. A list of exceptions to the general rule of legal confidentiality is provided in the Colorado Revised Statute 12-42-218. Sexual intimacy between a client and therapist is never appropriate and should be reported to the governing board immediately.

If you have any questions or would like additional information, please feel free to ask.

### **Consent for Treatment**

I voluntarily consent to mental health and/or consultative services with Brenna Tindall, Psy.D. of Arête Psychological Services, LLC. I understand that Dr. Tindall is also being supervised by License Psychologist, Rick May, Psy.D. and give her permission to consult

with him regarding my case. I understand that by signing this form, I am giving her the authorization to do this.

### **Financial Agreement**

Standard Service Fees:

Please review the rates for the following services. The rates listed below are based on a 50minute clinical hour. Therapeutic sessions lasting over 50-minutes in length may be subject to additional service fees.

- Individual Adults: \$90-\$120
- Individual Children/Adolescents: \$90-\$120
- Couples and Families: \$100-120
- Phone Consults: \$50-100
- Emergency or After-Hours Consultations: \$110

If a report, letter or consultation with an outside party is requested, I understand I will be billed for any time needed to prepare documentation, or to conduct an in-person or phone consultation. My therapist's standard service fee (detailed above) will apply.

Discount Rates:

If you are currently receiving a rate reduction which has been previously arranged by your therapist, please enter this rate here: \_\_\_\_\_. This corresponds to a \_\_\_\_\_ % discount.

### **Forms of Payment & Payment Policies:**

This practice accepts the following forms of payment: Visa, MasterCard, Discover, and personal checks. Clients will be responsible for payment at the time services are rendered.

### **Cancellation Policy:**

In the event you need to cancel an appointment, please provide notice to your therapist within 24 hours of your scheduled appointment time. If sufficient notice of a cancellation is not provided, or no notice is given at all, your therapist's standard service fee as agreed upon in this disclosure will be assessed for that session.

### **Insurance:**

This practice does not directly bill through any insurance or medical plan; however, insurance-ready statements will be emailed to you at the end of each month detailing any direct payments you have made to the practice. These statements can be used to initiate the reimbursement process privately through your insurance company if you choose.

**Policy for Non-Payment:**

In the event billing efforts fail, delinquent accounts may be subject to collections. This therapist will make every attempt to develop a payment plan with any client struggling to pay a past due balance prior to sending a balance to collections.

**Required Signatures**

I understand and agree to the preceding Disclosure Statement, Consent for Treatment, Financial Agreement and the Additional Information provided directly above. I also understand my rights as a client/patient.

Client/Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Clinical Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

