

DISCLOSURE & CONSENT TO TREAT

1. ABOUT this PSYCHOTHERAPIST:

I hold a Masters level degree in Somatic Counseling Psychology from Naropa University (2009) with a dual track in Body Psychotherapy and Dance/Movement Therapy and a BA from San Francisco State University where I majored in Sociology (1997) which a specialization in Human Sexuality. I am a Licensed Counselor in Nevada and Colorado. I provide telehealth sessions for Nevada clients, and both telehealth and in-person sessions to Colorado clients. Additionally, I am a Certified Internal Family Systems Therapist with the Center for Self-Leadership, a Registered Dance/Movement Therapist with the American Dance Therapy Association and a Registered Yoga Teacher (15395) with Yoga Alliance. I was Nationally Certified in Therapeutic Massage and Bodywork (025785-00) from 1993-2017. I have extensively studied the use of Psychotherapeutic Touch, and use touch in my practice where appropriate and with client consent.

I practice Holistic Integrative Psychotherapy, an approach to psychotherapy that selects what is useful from available and known theories, methods, and practices. The eclectic approach is an attempt to match appropriate clinical methods to each client and her/his situation.

I work from a systems perspective, that is, I take into consideration the individual and the cultural context in which she/he exists. As an Internal Family Systems Therapist, I work to help people integrate the different parts of themselves and to help them place their wise Self in a leadership role within their internal psychological system. My approach is humanist and client-centered, with a strong emphasis on experiential techniques, such as those of Hakomi, Gestalt, movement and other body-awareness based therapies. As a reverend and interfaith spiritual counselor, I work within each clients' faith system to incorporate spiritual health within the framework of psychotherapy. I also incorporate the creative arts whenever useful and appropriate. I have ten years experience working with these approaches.

As a Somatic Psychotherapist, and Body-Centered Psychotherapist, I may incorporate hands-on work into our sessions. If I believe that hands-on work is in your best therapeutic interest, I will discuss it with you prior to any physical engagement. You will never be touched sexually, nor will you ever be touched without your consent. You always have a right to stop any therapeutic process (whether that process includes touch or not) at any time.

2. ABOUT your CLIENT RIGHTS:

If you have any grievances or concerns about the therapeutic services provided, I invite you to address those concerns with me directly.

The Nevada Board of Examiners for Marriage & Family Therapists & Clinical Professional Counselors has the general responsibility of regulating the practice of Clinical Professional Counselors. Grievances can be mailed to P.O. Box 370130 Las Vegas, NV 89137-0130, you may call the board at 702-486-7388 or email the board at nvmftbd@mftbd.nv.gov

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of Licensed Professional Counselors. Their address is 1560 Broadway, Suite 1350, Denver, CO 80202, email is dora_dpo_licensing@state.co.us and phone number is 303-894-7800. Complaints may be filed at <https://apps.colorado.gov/dora/licensing/Activities/Complaint.aspx>

Client Rights and Important Information:

- a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.
- b. You can seek a second opinion from another therapist or terminate therapy at any time.
- c. 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 State Grievance Board.
- d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the clients' consent.
- e. Information disclosed to a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, or a licensed psychologist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Nevada without the consent of the person to whom the testimony sought relates.
- f. There are legal exceptions to the general rule of legal confidentiality. Generally, they are:
 - i. intent to harm others or yourself
 - ii. abuse or suspected abuse of children, and possibly the abuse of the elderly or others unable to care for themselves
 - iii. neglect or suspected neglect of children
 - iv. you file suit against me or I am being reviewed by the grievance board
 - v. subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child-custody, divorce and other court cases.
 - vi. Except in the case of information given to a licensed psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding.
 - vii. illegal sexual relations with current or former psychotherapists.In these instances, disclosure will only be among the investigating persons. A full list of exceptions is listed in the Nevada and Colorado statutes.
- g. You agree to pay for psychotherapy appointments; My full professional rate is \$170 per therapeutic hour. This higher rate covers the work that is done outside of the therapeutic session such as treatment planning and care coordination with other health care providers. Upon request, you will be provided a bill to request reimbursement from your insurance company. If paying for services at the time they are rendered is impossible for you, I have an insurance biller that can bill for you directly. The insurance biller charges 8% of the remittance, which will be passed on to you.
- h. My day of services rates are \$170 per therapeutic hour. Day of service rates are available for those who do not have insurance coverage and are paying the day the service is provided. If you have an FSA or HAS plan and are using it to pay for your sessions, the day of service rate applies.
- i. You agree to pay for phone consultations. I offer in-between session phone support. When phone calls are relatively brief, I do not charge. However, phone consultations and phone sessions that are about 15-minutes are billed \$40 for each quarter-hour. Your insurance will not reimburse you for telephone support/consultation.

3. AS A PSYCHOTHERAPY CLIENT, or Parent of a child client, YOU UNDERSTAND THAT:

- a. I, Sabrina Santa Clara will not (at the request of the client) testify in court as an expert witness, including: divorce, child custody, or criminal cases. I will not release information to or communicate with another therapist (holding any scholastic degree), a child advocate, an attorney, or any other professional requiring confidential therapy information, unless Release of Information forms are signed indicating consent of consultation between Sabrina Santa Clara and another clinician, school or similar professional. The exception to this is when I seek clinical supervision; should this occur, I will not provide identifying information to such peer or supervisor. I will provide client summaries of progress, or final treatment summaries if requested by parent/client. An hourly rate

- equivalent to the therapeutic rate will be charged for such services. Note that your insurance company will not reimburse you for the fees associated with these types of services. Your client file is the property of Sabrina Santa Clara, PLLC. In case of death or incapacity of your therapist, client files will be transferred to Gina Abbeduto, PLLC.
- b. If I am subpoenaed by the Court, that court testimony on your behalf is charged at a higher rate of \$800.00 per hour including: testimony related matters like case research, report writing, travel, depositions, actual testimony and cross examination time and courtroom waiting time. Signing this disclosure statement gives me permission to release confidential information in courtroom testimony and written reports to the Court if requested by the Court and if I am legally obligated to comply.
 - c. Signing this form indicates your consent to evaluation and mental health treatment for your minor child or yourself. Care and treatment is not an exact science and you acknowledge that no guarantees have been made to you as to the result of treatment.
 - d. I am not a “crisis” response therapist. If you (or your child) have (has) a life-threatening emergency, you will need to call the Suicide Prevention Lifeline at (800) 273-8255, the police (911) or go to my nearest emergency room. If I think you need more intensive services you will be referred a therapist or organization that has the ability to provide treatment to meet those needs.
 - e. I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of her scope of practice, I am legally required to refer, terminate, report, or consult.
 - f. There may be times when I may need to consult with a colleague or another professional, like an attorney, about issues raised by you in therapy. Your confidentiality is still protected during consultation by your psychotherapist and the professional consulted. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.
 - g. **You must provide 48-hours notice of cancelling. Cancellations must be made by calling or texting 303.955.8945 (not by email). If you do not give 48-hours prior notice of cancellation, you will be charged late cancellation fee equivalent to half the session fee. If you do not show to your appointment or cancel with less than 24-hours notice you will be charged a no-show/cancellation fee for the full cost of your session.**
 - h. Like any other professional service, you must pay for all psychotherapy services (psychotherapy in the office, parent consultations, phone calls, and the like) you receive as a client or parent of a child client. If you do not pay for services received you understand you may be turned over to a collection agency to recover payment for Sabrina Santa Clara, PLLC . You must repay the full amount and any bank fees or other relevant costs for bounced checks.
 - i. **Confidentiality cannot be assured when using electronic communication like cell phones, texting, video, e-mails, and faxing. If you choose to communicate with me by these electronic means, I cannot be responsible or liable for breach of confidentiality. Unless you provide written notice to me prohibiting the use of electronic means of communication, then it will be considered that you have given me permission to use these forms of communication.**
 - j. The boundaries between therapist and client are legally mandated to protect clients. Harmful dual relationships are prohibited. This means that clients may not be added to my personal facebook page. **I have a professional facebook page that you are welcome to follow. On that page I post helpful articles and local events I may offer.** Those who follow this page may or may not be clients. This page is a public forum in which I post articles, quotes and events in the Greater area that are geared toward health, healing and spirituality. Liking this page or posting a response on this page will be considered a client’s choice to relinquish confidentiality in that medium, though I will never identify anyone on that page as a client. My professional facebook page is <https://www.facebook.com/Sabrina.SantaClara>

4. CLIENT SIGNATURE, ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT
I have read the preceding information and understand my rights as a client or parent/guardian to my minor child, as well as agree to the terms discussed in this policy statement.
5. HIPPA ACKNOWLEDGEMENT:
I have been offered or have received a copy of the HIPPA Notice of Privacy Rights.

Client/Child name: _____ Date of Birth _____

Client/Parent Signature _____ Date of Signature _____

Client Signature (if 15 years of age or older) _____ Date of Signature _____

Sabrina Santa Clara, PLLC _____ Date of Signature _____