**Carol Grace, MA, LMFT**
**Licensed Marriage and Family Therapist, Colorado License #320**
**Aspen and Mid-Valley Counseling (970) 920-7683**

**Qualifications and Nature of Counseling: Integral Holistic Health Counselor**
**(Integral: Mind, Body, Spirit in relationship with Self, Community, Environment)**

**I am pleased you have selected me as your psychotherapist. This document is designed to inform you about my background and to insure that you understand our professional relationship.**

**I hold a Marriage and Family Therapist License (LMFT), with a Master's Degree in Counseling Psychology from John F. Kennedy University; emphases in clinical, marriage, family and holistic health counseling. I have been a professional practitioner in the Roaring Fork Valley since 1992. My professional addresses are 0189 JW Dr., El Jebel and at The Kistner Institute, Aspen. Office hours are Monday through Friday, 8:30 A.M. to 7:00 P.M. Out of office on Wednesdays. I am a Clinical Member of the American Association of Marriage and Family Therapists. My counseling practice includes individuals, couples, families, adolescents and group therapy; may deal with a variety of issues and be administered with complementary approaches as part of a comprehensive, integral treatment plan.**

**I accept only clients in my private practice that I believe have the capacity to resolve their own problems, with my assistance. I believe as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. Self-awareness, self-acceptance, and changes in dysfunctional patterns of individuals or family groups are goals that sometimes take a long time to achieve. Some clients need only a few counseling sessions to achieve these goals, while others may require months or even years of counseling.**

**My clients are assumed to be self-responsible (e.g., not in need of day-to-day supervision). As a private practice clinician, I cannot assume responsibility for clients' day-to-day functioning, as can institutions. If after-hours self-care is necessary, appropriate referrals can be discussed. You may seek a second opinion or terminate the counseling relationship at any point. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may request a referral to another counseling source. In addition, we may discuss referrals to other healing sources such as physicians, body workers, or nutritional consultants.**

**Fees, Cancellation, and Insurance Reimbursement:**

**In return for a fee of $165 - $210 (Aspen) per 50 minute session (longer is pro-rated), I agree to provide services for you. Couple sessions: recommended 1.5-2 hours. These rates apply to all scheduled office appointments, relevant telephone contacts over five minutes, consultations with physicians, attorneys, educators, agencies, other professionals or individuals. The fee for each session will be due and must be paid at the beginning or conclusion of each session via cash, personal check or credit cards ($5 additional charge for credit cards). Exceptions to the above fees are EAP or insurance plans for which I am a provider or another plan which was discussed.**

*****In the event that you will not be able to keep an appointment, you must notify me a minimum of 24 hours in advance. If I do not receive such advance**

**notice, you will be responsible for paying for the session that you missed. If you can re-schedule within the same week, this charge may not apply.**

**Insurance Policy: Some health insurance companies will reimburse clients for counseling services and some will not. Most will require that I diagnose your mental health condition and indicate that you have an illness before they will agree to reimbursement. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis I plan to render before I submit it to the health insurance company. Any diagnosis made will be part of your permanent insurance records, and I have no control of or responsibility for confidentiality procedures employed by your insurance company or other third parties.**

**With some exceptions, you will be paying me each session for my services. Contact a company representative to determine whether your insurance company will reimburse you and what schedule of reimbursement is used. Your statement will contain the information required by insurance companies. You remain responsible for payment in full should treatment recommendations exceed third-party coverage or financing or if for any reason your fee is not covered and paid to me. If I am a provider for your insurance company, I will file the necessary forms; you will be responsible for any co-payment and to know if your deductible is met.**

**Internet, Cell Phones: Any information through technology may not be confidential. Therefore, I recommend that all such communication be limited to scheduling.**

**Records and Confidentiality**

**All of our communication becomes part of the clinical record. I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else, b) I determine that you are a danger to yourself or others: child abuse, elder abuse, suicide, homicide or grave disability, c) I am ordered by a court to disclose information. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Colorado State Grievance Board.**

**For divorced parents with children: When parents are divorced, Colorado law allows any parent who has been assigned parental responsibilities access to medical records. Therefore, in compliance with CRS 140-10-123.8, you authorize me to provide access to treatment information to such an individual by authorizing me to provide services to a child in your custody. Under 15 years, consent is to parent.**

****When meeting with one individual of a couple, I am not responsible for secrets and encourage safe, open communication.**

**By your signature below, you have indicated that you have read and understood this statement and any questions you have had about this statement have been answered to your satisfaction. (see Page 3 addendum at the office)**

_____ _____

**Name and Signature** **Date**

**Address/Phone Number:** **Parent or Guardian (if applicable)**