DISCLOSURE STATEMENT

1. **Therapist**: Theodore Mathis – 12500 W. 58th Ave, Suite 220, Arvada, CO 80002 – 720-319-1267

2. **Education and Experience**:
   - BS Chemical Engineering, SD School of Mines – May, 1976.
   - Master of Arts in Community Counseling, Denver Seminary – December, 2009.
   - Clinical Care Coordinator, Arapahoe Douglas Mental Health – November, 2009 to May, 2012.
   - Registered Psychotherapist – January, 2010 to June, 2012.
   - Counselor, Resonance Counseling, Arvada, CO – April, 2010 to present.
   - Nationally Certified Counselor – April, 2010 to October, 2013.
   - EMDR (Level I and II) Training – May to October, 2010.
   - Therapy Interfering Behaviors Training – June to November, 2011.
   - Licensed Professional Counselor – June, 2012 to present.

3. **Registration and Licensing**: 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 Board of Registered Psychotherapist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202; or (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: A Registered Psychotherapist is a psychotherapist listed in the State'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. A Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. A Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Licensed Social Worker must hold a masters 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 their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. **I am a Licensed Professional Counselor (LPC).**

4. **Therapy and fees**: You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

5. **Prohibited Relationships**: In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

6. **Confidentiality**: Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mentalhealth/Statute.pdf.

I have read the preceding information, and I understand my rights as a client or as the client's responsible party.

_____ _____

Print Client's Name Date

_____ _____

Client or Responsible Party's Signature Relationship to Client

Ted Mathis, MA, LPC

12500 W. 58th Ave, Suite 220, Arvada, CO 80002 - (720) 319-1267

INFORMED CONSENT

*Please **initial** each statement in the blank provided*

_____ My fee for a 50-minute session Monday-Friday 8-5 is $95.00 ($100 for cash), payable at the time of the session. I accept credit, debit, and HSA cards, and checks. Fees are subject to change every 6 months. Fees for sessions outside normal business hours are negotiable.

_____ Telephone calls, emails, and texts except for the purpose of logistics (scheduling, billing, etc.) will be billed at the above rates. Note: emails and texts are not considered to be a confidential means of communication.

_____ Fees, as per above, will be charged for any additional services rendered by me at your request, such as assessments, preparation of letters, special forms, insurance reports, court time, consultation with other professionals, etc.

_____I am not on call for emergencies. If you have an emergency, please dial 911 or go to the nearest emergency facility. Emergency-related activity will be billed at the above rates.

_____If you have insurance coverage, I would be happy to supply you with a receipt or periodic statement. I do not accept direct assignment of benefits from insurance companies, nor do I participate in managed care insurance plans (HMO/PPOs).

_____Your visit has been reserved for you. **24 hours notice** is required for cancellation, or you will be charged a late cancellation fee of $50. However, *failure to appear* with no advance notice is billed at the **full fee** of the planned session.

_____ Unattended children are not permitted in the waiting area.

My signature below indicates I have read and understood the above information.

_____	_____
Print Client's Name	Date
_____	_____
Client or Responsible Party's Signature	Relationship to Client

Ted Mathis, MA, LPC

12500 W. 58th Ave, Suite 220, Arvada, CO 80002 - (720) 319-1267

CLIENT INFORMATION: **Date:**_____

Name:_____

Address:_____City:_____

State:_____Zip:_____

Phone: (home)_____(cell)_____

Work phone: _____ email: _____

Date of Birth:_____

Employer:_____ Occupation:_____

List history of significant health problems:_____
_____
_____
_____
_____
_____

List history of medications and dosage (if known):_____
_____
_____
_____
_____
_____

Name/Phone# of nearest relative other than spouse:_____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name:_____Relationship to Client:_____

Phone (if different from above):_____

Address (if different from above):_____