Stephen W. Koelemay, PsyD

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303.775.8660

CLIENT INFORMATION AND CONSENT TO TREATMENT

Welcome to the office of Dr. Stephen W. Koelemay. The following paragraphs provide information, which is important to you as a client. Please read the information carefully and ask if you have any additional questions.

EDUCATION AND TRAINING

I received my Psy. D. in Clinical Psychology from the University of Denver and completed my internship at Wardenburg Heath Center – Psychological Health and Psychiatry at University of Colorado. I completed my post-doctoral fellowship at the University of Colorado – Counseling and Psychological Services. I am currently licensed as a Psychologist in Colorado, license #3947, granted by the Colorado State Board of Psychological Examiners.

The practice of both licensed and registered persons in the field of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies. Any concerns may be addressed to the appropriate licensing board or:

- Colorado State Grievance Board; 1560 Broadway Street; Suite 1350; Denver, CO 80202; 303-894-7800
- As to the regulatory requirements applicable to mental health professionals: A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

OFFICE POLICIES AND PROCEDURES

APPOINTMENTS: Therapy sessions are 45 minutes. This time is reserved for you. In the case that you need to cancel or reschedule an appointment, 24-hour advance notice is required. With less than 24 hours notice, you will be charged the full amount for the session. This will be your responsibility and cannot be charged to insurance.

Emergencies: This practice is not a 24 hour crisis intervention agency. In case of an emergency you should call 911 or go to the nearest hospital emergency room. I am usually able to return calls within the same business day, however, in case of a life-threatening crisis; you should go to the nearest hospital emergency room or call 911.

Messages: I can be reached at (303) 775-8660. If I am unable to answer the phone, please leave a message on my confidential voice mail. I typically check my messages several times a day and return calls as soon as possible.

Fees: The fee for each counseling session is $160.00. Payment is expected at the end of each session unless prior arrangements have been made. If requested, I will give you a bill, which you can submit to your insurance company. If you end therapy with an unpaid balance and do not make arrangements to settle the bill, your account may be turned over to a collection agency. Any costs incurred in the collection are your responsibility.

Telephone conversations of a clinical nature may be charged as regular sessions. Reports and court appearances require professional time for which I charge the full rate of $160.00; court appearances require 4-hour minimum. If the court appearance is rescheduled or cancelled I will bill for the time reserved for the appearance.

CLIENT RIGHTS

You are entitled to receive information about methods of therapy, the techniques used, the duration of therapy if known, and the fee. You may seek a second opinion from another therapist and may terminate therapy at any time. In a professional therapy relationship, sexual intimacy is never appropriate and is illegal in Colorado. It should be reported to the Grievance Board.

The information provided by you during therapy is legally confidential except as required by law. There are exceptions to the rule of confidentiality. In general, these exceptions include:

1. The law requires reporting cases in which:
   - the client may present a danger to self or others,
   - there is indication of child abuse or neglect.

2. Therapist(s) and/or records may be subpoenaed in Court proceedings including but not limited to child custody, criminal, and delinquency cases.

If exceptions arise regarding confidentiality, they will be discussed with you.

During the course of psychotherapy, material may be discussed, which may be upsetting to you. This may be necessary to help you resolve your difficulties. Although there is no assurance that you will feel better, psychotherapy is more likely to be successful if we work cooperatively. I strongly encourage you to bring up any questions or concerns that you may have as they arise.

Your signature below indicates that you have read, understand, and agree to the preceding information. Your signature also indicates that you have been provided a copy of the Notice of Privacy Practices and indicates consent to treatment at S. W. Koelemay Psychology, LLC. For families, your signature attests that you are authorized to give permission for your child(ren) to have counseling with Stephen W. Koelemay, Psy. D.

_____		_____	_____
Client Printed Name		Adult Signature	Date

_____	_____	_____	_____
Parent/Guardian Signature (of children age 14 and under)	Date	Teen Signature (ages 15-18)	Date

_____	_____
Therapist signature	Date