Country Counseling, LLC

970-286-7856
www.countrycounselingllc.com

832 W. Eisenhower Blvd, Suite E
Loveland, CO 80537

Welcome to therapy at Country Counseling, LLC! I am excited to work with you and help you overcome whatever struggles you may have**. Please take time to read ALL of the information within this packet.** Make sure to mark all parts that are unclear and we will review them during our next session.

Therapist Information

Kathy Korell-Rach, Ph.D.

- Licensed Clinical Psychologist, Colorado License: PSY.0004016
- Doctorate of Philosophy in Clinical Psychology, Conferred August 2011, University of North Dakota
- National Provider Identifier (NPI) 1093028722

Psychological Services

Our initial sessions will be devoted to gathering information and assessing your needs to create a treatment plan that will guide our work together. I utilize many different methods to help you reach your goals and would be happy to provide specific information about those approaches at your request. I strongly encourage feedback throughout the therapy process to make sure you are satisfied with your treatment. Unfortunately, it is difficult to predict how long we will need to meet in order to meet your treatment goals. Some factors that influence duration include symptom severity, motivation to change, and the nature of the goals. My aim is to make each session as productive as possible.

There are risks and benefits to any treatment, and psychotherapy is no exception. You will likely experience discomfort as you confront and share the aspects of your life that you want to change; you can expect to feel anxious, embarrassed, and/or sad after our initial sessions. *This is normal.* Often times, unpleasant emotions get worse or more intense before they get better. However, healing begins even if things feel worse initially.

Ethical and Legal Concerns

The Colorado Department of Regulatory Agencies (DORA) and the State Board of Psychologist Examiners are both regulatory agencies that control the practice of psychotherapy. Concerns or complaints may be directed to:

- DORA Division of Professions and Occupations, 1560 Broadway, Suite 1350, Denver, CO 80202; (303) 894-7800
- State Board of Psychologist Examiners, 1560 Broadway, Suite 1350, Denver, CO 80202; (303) 894-2291

In a professional relationship, sexual intimacy is NEVER appropriate and should be reported.

Confidentiality

In general, all information you share with me, as well as my records about you, are confidential by law. However, there are exceptions, which are listed in the Colorado Statues (see section 12-43-218, C.R.S. (1988), in particular). The most common exceptions are:

- If I am directed to release information by a judge in a court of law
- If you were sent to me by court or an employer for evaluation or treatment
- If I believe you are in imminent danger of harming yourself or another person or if you are gravely disabled. This usually means calling your emergency contact person, initiating the procedure for a 72-hour hold, calling the police, and/or contacting a named victim.
- If I believe a child or another dependent individual (e.g., elders, adults with severe developmental disabilities, etc.) has been or will be abused or neglected.
- If you do not pay your bills, I reserve the right to use a collection agency.
- I may consult with other professionals, without revealing identifying information about you, in order to provide the most effective treatment possible. These professionals are bound by the same confidentiality laws that apply to me.
- Employed office staff will have access to your records in order to complete job requirements, such as billing. All staff members are bound by the same confidentiality laws that apply to us.

Often, it is beneficial for me to communicate with your other providers and/or significant others in your life to make sure that you receive the best care possible. I can only exchange protected health information (either verbally or through written records) if you sign a **Release of Information** for said persons. If I will be unavailable for an extended period of time I may select a trusted fellow therapist to "cover" for me and will ask you to sign a release of information for that specific professional.

If you are in the waiting area and recognize any individual who may be leaving or waiting for a session, I expect for you to maintain the confidentiality of this person. Similarly, if you are participating in group therapy, I also expect for you to maintain the confidentiality of other group members.

Professional Records

I have a legal duty to maintain accurate client records. You have the right to review your records and receive copies of them at any point in time. You may add to or correct your records. You may not examine records created by anyone else and sent to me. Professional records can be misinterpreted, so I would encourage you to review your records in my presence so that you can ask questions. In some very rare situations, I may remove parts of your records before you see them if I believe that the information would be harmful to you.

Appointment Information and Billing

We will usually meet for weekly 50-minute individual sessions, unless scheduled differently. Please be on time to sessions. If you are late, you will be able to utilize the remainder of your scheduled time and charged the full customary rate for the session. When you must cancel a session, I require at least 24 hours notice. You will be charged 50% of your session rate for all late cancelations and missed appointments. Insurance will not reimburse for late cancellation or missed appointment charges, so you will be solely responsible for these charges.

I accept fee-for-service in the form of cash, check, or credit card. My current regular fees are $100 per 50-minute individual therapy session and $50 per 90-minute group therapy session.

If you require additional services outside of scheduled appointments (e.g., phone calls, report writing, etc.), you will be charged a pro-rated amount based on the time utilized after the first 15 minutes. You will be given advance notice if my fees should change. Payment is expected at the time of service. I will provide you with a monthly statement reflecting all of our meetings, the charges, and fees paid. You may submit this statement to your insurance company to file for full or partial reimbursement. I can make no guarantee that insurance will reimburse your request. However, I am happy to provide any required information you may need.

If you do not pay outstanding bills within 90 days of the first delinquent charge, I reserve the right to use a collection agency. I do not want to use this option, so please tell me in advance of any financial difficulties you may have so that we can make a payment agreement.

If You Need to Contact Me

I cannot promise that I will be available at all times. I do not take calls when I am with clients in session. You can always leave a message on my confidential voicemail at: 970-286-7856.

Please initial indicating that you understand the following statements and will adhere to these procedures:

_____I will return calls as soon as possible. You can expect a return call within 24 hours, except on Saturdays, Sundays, and holidays, or as specified in my voicemail greeting. If I will be out of town for an extended period of time that includes regular working days, my voicemail will provide contact information for another professional.

_____If you have a **life-threatening or potentially life-threatening emergency or crisis** and cannot reach me by telephone you agree to leave a message on my voicemail AND Call 911 or go to the nearest emergency room.

In Loveland:	In Fort Collins:	In Longmont:
McKee Medical Center	Poudre Valley Hospital	Longmont United Hospital
2000 Boise Ave.	1024 S. Lemay Ave.	1950 Mountainview Ave.
Loveland, CO 80538	Fort Collins, CO 80524	Longmont, CO 80501
970-669-4640	970-495-8020	303-651-500

_____For a **non-life-threatening emergency or crisis**, you agree to leave a message on my voicemail AND call Touchstone Health Partners After-Hours Non-Life-Threatening Emergency Hotline at 970-221-2114.

_____Email is not a secure form of communication, so it is reserved for scheduling and other non-clinical information. If you choose to send sensitive information or request a reply that would include sensitive information, please be aware of the risks to your protected health information.

Statement of Principles

In my practice as a psychologist, I do not discriminate against clients because of age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment as well as being required by federal, state, and local laws and regulations. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Consent to Treatment and Agreement to Pay

I acknowledge that I have received, read (or have had read to me), and fully understand all information presented above. I have had all of my questions answered fully and formally agree to abide by the terms of this document. I understand my rights and responsibilities as a client, and/or I understand the rights and responsibilities of my minor child as a client and my own rights and responsibilities as a legal guardian. I have retained a full copy of this document for my records. I consent to participate in therapy, or give my consent for my minor child to take part in therapy. I agree to pay the following fees for service: $_____ per 50 minute individual session $_____ per 90 minute group session.

_____ _____
Signature of Client (or client's legal guardian) Date

_____
Printed Name of Client (or client's legal guardian)

If client is a minor: I give my assent to treatment. This means that I want to participate in therapy. I have had all information in this form explained to me and I understand what it means.

_____ _____
Signature of Minor Client Date

_____
Printed Name of Minor Client

_____ _____
Signature of Financially Responsible Party Date
(If not client or minor client's legal guardian)

_____
Printed Name of Financially Responsible Party

This is a strictly confidential patient medical record and protected by HIPAA.
Redisclosure or transfer is expressly prohibited by law.