

Crossroads Counseling Associates

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303.920.8771 Office, 303.920.8774 Fax, www.crossroadscounselingassoc.com
Disclosure and Consent Form

Della M. Seaton, M.A.

Thank you for choosing Crossroads Counseling Associates. We seek to provide you with quality, time effective treatment to individuals, couples, and families, regardless of age, race, sex, or religious affiliation. Christian counseling and the use of spiritual resources are available for clients who request them.

Counseling is a cooperative process in which we work together as a team to identify the issues that brought you here, causes, and possible solutions. I will be honest and respectful of you, listening carefully to what you have to say. I expect you to be open and honest with me as well. I am not here to tell you what to do, but to help you find strategies that fit into your living situation, personality, strengths and weaknesses.

During our initial session we will go over your background information and current concerns, so that I can get to know you, so it is important that you fill out the information sheet as completely as possible. I want to know what you expect from our sessions, and what you hope to achieve. We will decide together how long we expect counseling to continue, and how we will know when to conclude counseling. I believe that you will be able to find the strength and tools you need and our sessions should not be a long-term process. However, if you need more time, we will take more time. As part of counseling, I will give you 'homework' of various kinds to complete on your own. Your agreement to be an active participant in your own well-being is an essential part of we will be doing. If you cannot fulfill this part of our task, it will not be possible for us to work together.

Disclosures:

- The Colorado Department of Regulatory Agencies oversees psychotherapy practice: Department of Regulatory Agencies, Division of Registrations, Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7800
- Sexual contact between a therapist and client is never appropriate and should be reported immediately to the state board (above)
- You are entitled to seek a second opinion or terminate treatment at any time.
- You are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy if known, and the fee structure.

- I hold a Master's of Professional Counseling from Liberty University, Lynchburg, VA, and am currently pursuing hours for licensure for the state of Colorado. I earned a B.S. in Organizational Management - Human Resources from Colorado Christian University, Lakewood, CO, in 2006. OVER
- My supervisor is Dr. Ron Veatch, Director of Crossroads Counseling Associates. As such, I will discuss client issues with him. Your confidentiality is protected by both Dr. Veatch and me. If you have any questions or problems with your course of treatment, please feel free to contact Dr. Veatch at 303.920.8771
- Unless directed by the court I do not testify in legal proceedings.

Confidentiality is an essential part of our counseling relationship and protected by law. I will not disclose, without your written permission, any information about you to other parties with the following exceptions:

- If you pose a serious physical danger to yourself or others.
- If you disclose that you or another person has physically or sexually abused, molested, or neglected a child, an incompetent person, an elderly or disabled person.
- If required to do so by law.
- If consulting with my supervisor, who is also bound by confidentiality.

Payment of \$____, for a 50-minute session, at the time of services is expected. Phone calls over 10 minutes in length will incur a session fee. I may also be able to refer you to low, or no cost counseling centers. I do not accept or bill for insurance but will give you an insurance form upon request.

Cancellations should be made at least 24 hours in advance. I reserve the right to charge for missed sessions.

Emergencies. In the event of an emergency, call 911. In an urgent situation, but not a crisis, feel free to call my office and leave a message for Dr. Veatch or myself.

Financial Agreement and Authorization for Treatment:

Attesting that I understand the above and agree to therapy under the above list of disclosures, I sign below. I also understand that consistent with HIPPA requirements, consent to treatment and consent to release information will expire after 12 months, and I may revoke such consent at will, although the revocation is not retroactive.

Signature of patient, or if under 15 years (Colorado), parent/legal guardian

Date

Signature of therapist

Date