THERAPIST INFORMATION AND DISCLOSURE STATEMENT

Jay Brandenburg-Nau MA LPC
Colorado Licensed Professional Counselor LPC.0012285

8321 Sangre De Cristo Rd.
Suite 200
Littleton, CO 80127

Emergency: Crisis Line 720-883-6387 or 911

Training and Degrees:
B.A. in Secondary Education University of Montana Western, 2000.
M.A. in Counseling from Denver Seminary Denver, CO, 2010.

I have created this document to provide you with a copy of information regarding my therapeutic qualifications and orientation, your rights as a client, and our financial agreement. Please read the information contained in this document carefully and retain it for future reference. If you have any questions regarding the information contained in this document, please address them to me.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80201, (303) 894-7800.

Counseling Orientation, Techniques, and Methods: The model around which I have developed my counseling style is highly relational. Rather than diagnosing and labeling the complexity of your life, I will maintain a relational stance and interact with you in such a way that will allow you to function outside the commonly held barriers of the diagnostic system.

Although we will spend significant time exploring the issue(s) and problem(s) that led you to counseling, we will also look at the nature of your relationships with other significant people in your life. According to my counseling orientation, I believe that many of the forces and dynamics that have influenced the complexity and intensity of your problem(s) are rooted in relational issues. I believe that many of these relational

issues manifest themselves in other areas of life, and only by looking at the issues in your significant relationships will these other issues be addressable or resolved.

Your Rights as a Client: You have several rights regarding your treatment.

- You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure.
- You have the right to seek a second opinion from another therapist or terminate therapy at any time. I can provide a referral should you want to see another therapist.
- According to Colorado State law the following phrasing is a requirement in all psychotherapist disclosure statements: "In a professional relationship (such as ours), sexual intimacy between a therapist and client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section."
- You have the right to contact the Department of Health with any complaints about your treatment. The Colorado State Department of Health Professional Quality Assurance at (303) 894-7855.

Confidentiality: There is a legal privilege in the state of Colorado maintaining the confidentiality of the information that you share with me. No one other than you has access to your information without your written consent. Information disclosed to me is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. Information disclosed by a client during a therapy session is legally confidential in the case of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed or certified addiction counselors, and unlicensed psychotherapists except as provided in the Colorado statutes (C.R.S. 12-43-218). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. There are exceptions that I will identify to you as the situations arise during therapy.

I also consult with other professionals regarding clients with whom I am working. This allows me to gain a fuller perspective of the issues we discuss, thus enabling our work to most effectively accomplish our goals. All consultations are intended to benefit the therapeutic process, and all information is exchanged in such a manner as to maintain strict confidentiality.

Financial Agreement: My fees are based on a 50 minute session. The fee is $135 per session for individual therapy and $165 for Couples therapy unless otherwise agreed

upon. Payments are to be in the form of a check, cash or major credit card (Visa, Master card, Discover card, and American Express) and are to be made at the beginning of each session. Fees may increase periodically over time. Please be reminded that I do not accept insurance, and that you are solely responsible for insurance claims, and are ultimately responsible for payment.

Contacting me by phone: You may leave a message at 720-883-6387. I will check these messages on a regular basis. Please limit your phone conversation needs to appointment scheduling and emergencies. All other calls outside these parameters will be billed at the prevailing rate of $135/hour for individual, $165/ hour for Couples.

Cancellation Policy: I adhere to a 48-hour cancellation policy. In the event that you cancel an appointment with less than 48 hours prior notice, you will be billed the full fee of the session.

Consent for Treatment:

- I have read and understand the Therapist Information and Disclosure Statement and understand my rights as a client/patient.
- I voluntarily consent to treatment with Jay Brandenburg-Nau, MA LPC

Client signature: _____

Client printed name: _____

Date: _____

Therapist signature: _____

Date: _____

Billing Address:_____

_____ State _____ ZIP_____

Email Address:_____

Phone number:_____
If a minor:
I give consent for my son/daughter to receive mental health treatment (sign below).

Parent or Guardian's signature: _____

Parent or Guardian's printed name:_____

Date: _____