Disclosure Statement

(Revised 4/25/2017)

Kimberly Reil, LPC CACII

1101 Village Rd. UL5C Carbondale, CO
0326 Highway 133 Suite A Carbondale, CO
1460 E. Valley Road Basalt, CO

Mailing address:
257 Red Dog Rd Carbondale, CO 81623
970-948-0709
kimreil@gmail.com

Education:

MA Clinical Mental Health, Adams State University, Alamosa, CO (May 2013)
MA Secondary Education, Regis University, Denver, CO (June 2006)
BA Fine Art, Lewis and Clark College, Portland, OR (May 2004)

Licenses:

Licensed Professional Counselor, State of Colorado, #LPC.0012488
Certified Addiction Counselor, State of Colorado, #ACB.0008023

Counselors practicing counseling for a fee must be registered or certified/licensed with the Colorado State Department of Licensing for the protection of public health and safety. Certification of a practitioner by the State is in no way recognition of practice standards or the effectiveness of any treatment.

1. Kimberly Reil is a licensed psychotherapist in the state of Colorado. She provides counseling for a broad range of issues including depression, anxiety, trauma, grief/loss and situational struggles. Kimberly uses a variety of evidence based models to address client concerns.

I have read the information on Kimberly Reil, LPC CAC II and have had the opportunity to ask any questions about her and/or my counseling program. I understand that she is in independent practice and occasionally consults with other licensed practitioners in a confidential manner.

Client Signature/Responsible Party Signature Date

2. Grievances against a therapist can be filed with the Board at:

1560 Broadway, Suite #1340
Denver, CO 80202
303-894-7800

3.You are entitled to receive information 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.

4. 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 Statues as well as other exceptions in Colorado and Federal law. For example, mental health professionals are mandated reporters required to report suspected child and elder abuse to authorities. Other limitations to confidentiality include suicidal ideation, homicidal ideation and the deeming of gravely disabled. 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/mental-health/Statute.pdf

5. **Disclosure of Information of Clients who are Minors**
In the interest of maintaining a trusting relationship with clients who are minors, the details of therapeutic sessions will not be shared with parents or other family members. Parents will be included in the treatment planning process if desired and included in the therapy process periodically. Information regarding general goals and progress will be shared periodically and as requested. In situations where a child or adolescent is my client, we can discuss these confidentiality issues in the first session. Should the client share information regarding potential harm to self or others, this information will be shared with the parents and appropriate agencies.

6. The counselor, Kimberly Reil LPC, CAC II, consults on a regular basis with a clinical supervisor regarding cases. Client confidentiality will be maintained during consultations.

I have read the preceding information, it has been provided verbally, and I understand my rights as a client or as the client's responsible party. I hereby release the above information to be shared with Kimberly Reil, LPC CACII.

_____

Client Signature/Responsible Party Signature Date

If not signed by the Responsible Party, please state relationship to client and authority to consent:

_____

_____

Counselor Signature Date

Counseling Services Agreement

This agreement for counseling services shall govern all relations between the parties signed below. It is agreed that any disputes or modifications of this agreement shall be negotiated directly between the parties. If negotiations are not satisfactory, the parties agree to mediate any differences with a mutually acceptable third party mediator.

1. THE COUNSELOR is Kimberly Reil, LPC CACII, Licensed Professional Counselor in the state of Colorado, #LPC. 0012488 and Certified Addiction Counselor in the state of Colorado, #ACB. 0008023.

2. COUNSELING at Kimberly Reil Therapy, LLC is confidential and uses a variety of evidence based modalities to best fit the individual needs of each client.

3. FEES AND INSURANCE POLICY: Client fees are determined at the initial intake interview. Full payment is due at each session. Clients understand that Kimberly Reil, LPC CACII is not listed under any insurance boards. If a client believes services rendered with Kimberly Reil Therapy, LLC are covered on their insurance policy it is the client's responsibility to bill their own insurance. Clients are fully responsible for the payment of all fees. The parent(s) or guardian(s) of a minor are responsible for full payment.

The fee for a 50-minute session (private pay client) is $100.00. Initial to confirm _____

4. LEGAL MATTERS/COURT ATTENDANCE: Any work done related to a legal issue on your behalf will be charged on an hourly basis for the time spent on your case. This includes meeting with your attorney, writing reports, travel, and preparation time. Client understands that Kimberly Reil, LPC CACII will not testify in court on behalf of the client unless it is in the client's best interest. Kimberly Reil requires a subpoena to appear and testify in court. Additionally, all subpoenas will be reviewed by Kimberly Reil, LPC CACII and her clinical supervisor, for determination of legal services.

5.CANCELLATION POLICY: Kimberly Reil Therapy, LLC asks that all clients maintain responsibility regarding appointment times. Appointments are scheduled with a frequency determined to be most beneficial. The time scheduled for your session is set-aside specifically for you. Please understand that payment of your bill is part of your treatment. If you miss a session without canceling, or if you cancel with less than 24 hours notice, you will be charged in full for the missed time. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate. Full payment is due at the time of service and must be in the form of either cash, check, or credit card. Extended payment plans and sliding scales for hardship situations are handled on an individual basis only.

6. EMERGENCY SERVICES: Counseling services with Kimberly Reil Therapy, LLC and Kimberly Reil, LPC CACII, is **NOT** an emergency service. If you have a mental health emergency, please call your local hospital, emergency services (911), Advocate Safehouse Project (domestic violence & sexual assault), Mind Springs Crisis Line (1-888-2074004), or Aspen Hope Center (970-925-5858 X1).

7. WORK AGREEMENT: It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as a priority at this time in his or her life. Client growth is extremely important and it is the commitment of Kimberly Reil Therapy, LLC to help facilitate this

gain. Alternative options will be discussed between counselor and client when unresolved conflict or impasses are hindering the counseling process.

The client has freely elected the counseling/treatment program offered by Kimberly Reil Therapy, LLC in good faith and without duress. I agree to defend, indemnify and hold Kimberly Reil Therapy, LLC, its principals, agents and employees harmless from and against any and all liability, loss or damage that I, as a client may suffer as result of claims, demands, cost, or judgments arising out of, in connection with, or incident to Kimberly Reil Therapy, LLC performance of services.

I have also received and read the HIPPA Compliance Notice of Privacy Practices provided on the AIC website and in hard copy upon my request. I have asked any questions that I desired in regard to this counseling agreement, services provided, fees, privacy practices, and payment policies.

Client Signature/Responsible Party Signature Date

If signed by the Responsible Party, please state relationship to client and authority to consent:

Counselor Signature Date

Informed Consent & Liability Waiver

It has been explained to me that counseling is not an exact science, and that I have the right to have a clear description of the nature and character of the proposed counseling. I also realize that I have treatment options outside of Kimberly Reil Therapy, LLC including no counseling at all and that no guarantee or assurance has been made to me as to the results that may be obtained from treatment with Kimberly Reil Therapy, LLC.

I affirm that I am in good health. I understand that therapy may include increased stress at moments and provide opportunities for relaxation, stress reduction and growth.

Client Signature/Responsible Party Signature Date

If signed by the Responsible Party, please state relationship to client and authority to consent:

Counselor Signature Date

Informed Consent Regarding the Use of Electronic Media

The use of electronic communication in regards to a confidential psychotherapy or coaching session has several elements that require client consent. By signing this form the client verifies that Kimberly Reil, LPC CACII has explained the appropriate uses of electronic communication in regards to confidentiality.

I understand that there are no promises of complete confidentiality in regards to the FCC, Homeland Security, hackers, and common data loss that may happen with electronic transmission use. Kimberly Reil Therapy, LLC and Kimberly Reil, LPC CACII strive to stay educated on the most recent forms of electronic security in regard to sharing information electronically and in compliance with HIPAA standards.

Personal Health Information (PHI) is any information that may identify you as a client and includes personal information about your physical and mental well-being. Your name, email address, date of birth and any other associated information are also considered PHI. It is very important to Kimberly Reil Therapy, LLC that your PHI is protected and therefore, the following steps will be taken to promote your confidentiality:

As a client of Kimberly Reil Therapy, LLC, I understand and consent to the following check list: (**please initial each section)**

_____ Psychotherapy sessions conducted over the phone are to include only Kimberly Reil, LPC CACII and the client(s). I understand that any phone charges I may incur from the session from my cellular or landline service provider are my financial responsibility. I understand I am responsible for finding a safe and confidential space from which to participate in the session.

_____Kimberly Reil Therapy, LLC uses Gmail for Business, which is HIPPA complaint. **Kimberly Reil Therapy, LLC cannot ensure complete confidentiality when a client sends emails from their personal email address since email service providers can access records of each email.** Therefore, Kimberly Reil Therapy requests that clients use the telephone for scheduling purposes or general questions.

_____Kimberly Reil Therapy, LLC acknowledges that using texting services to communicate can be very convenient for the client. Any text messaging is to be limited to scheduling confirmation, notification of cancellation, late arrivals, or problems in transit. **Kimberly Reil Therapy, LLC cannot ensure confidentiality when text messages are exchanged since phone companies have records of each transaction.** Therefore, I understand that Kimberly Reil Therapy, LLC requests that I use text messaging for the reasons listed above and I will not provide any Personal Health Information in any text correspondence.

_____Kimberly Reil Therapy, LLC uses "Square" Reader to accept credit cards, should the client want to utilize this method of payment. Square is PCI-DSS Level 1 compliant and the Square Reader is fully encrypted. Data encryption occurs at the moment of the credit card swipe or manual entry. If I choose to use this service then I understand and give my consent for Square's access to the personal identification/information inherent in a credit card transaction.

Kimberly Reil Therapy, LLC performs due diligence to provide the following:

1. Only Kimberly Reil, LPC CACII. has access to emails and texts sent to and from the client. These emails and texts are later sent to electronic trash after information about scheduling or questions are answered.

2. Use of confidential space to conduct all electronic conversations (email, Wi-Fi video conferencing, mobile conferencing).

3. Kimberly Reil Therapy, LLC's mobile device and computer are password protected and Kimberly Reil Therapy, LLC maintains password confidentiality from anyone outside of Kimberly Reil Therapy, LLC.

4. Kimberly Reil Therapy, LLC highly recommends that all clients password protect all of their electronic devices and keep their passwords confidential.

I understand and agree to Kimberly Reil Therapy, LLC's policies and recommendations around the use of electronic communication. I understand the inherent confidentiality risks involved with any type of electronic transmission and acknowledge the due diligence that Kimberly Reil Therapy, LLC performs to maintain confidentiality within its locus of control.

_____

Client Signature/Responsible Party Signature Date

If signed by the Responsible Party, please state relationship to client and authority to consent:

_____

Counselor Signature Date