

Disclosure Statement

1. David George Delaney, M.A., L.P.C. (Master's Degree; Counseling Psychology, Regis University; Licensed Professional Counselor Colorado license #4737), Licensed Body Centered Psychotherapist since 1983, (New York State), mailing address- P.O. Box 84 Boulder, CO., 80306, 303-449-2004.

2. My theoretical orientation is Integrative (Person-Centered, Transpersonal & Contemplative Psychology, Body-Centered, and Protoanalytic® Psychology) and I am trained in EMDR Trauma Therapy, NeuroCARE™ Neurofeedback, Couple Counseling, and Dialectical Behavior Therapy.

3. 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, certified school psychologists, and unlicensed therapists who practice psychotherapy. The agency within the Department that has the responsibility specifically for licensed/unlicensed psychotherapists is the State Grievance Board, 1560 Broadway, Suite # 1350, Denver, Colorado, 80202, (303)894-7766.

4. Client Rights and Important Information:

a. Ask me about anything related to your therapy at any time.

b. You can seek a second opinion from another therapist or terminate therapy at any time; I request that we speak prior to termination and that we have a final session to finish our work with each other.

c. In a professional relationship, sexual intimacy between a therapist and a client is never appropriate.

d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. The therapist cannot be forced to disclose the information without the client's consent. It is a privileged communication and cannot be disclosed in any court or competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony being sought relates. (There are exceptions to the general rule of confidentiality. These exceptions include intent to harm yourself or others: suspected abuse of children, and the abuse of elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child custody cases and orders to violate by judges in child custody and divorce court cases. You should be aware that, except in the case of information to a Licensed Psychologist, legal confidentiality does not apply in a criminal or delinquency proceeding, which there are exceptions to.)

5. There are times when I may need to consult with a colleague or another professional, about issues raised by clients in therapy. Client confidentiality is still protected during consultation by me and the professional consulted. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.

6. I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe that your issues are above my level of competence, or outside my scope of practice, I am legally required to refer, terminate, or consult. If, for any reason, you are unable to contact me at my telephone at 303-449-2004, and you are having a true emergency, please call 911 or check yourself into the nearest hospital emergency room.

7. I have a 24 hour cancellation/change policy. _____ *initial*

This means you need to call *before* 24 hours before the start of the session, not the “night before” and it means the reason is not a consideration. This policy’s sole and crucial purpose is to ensure our relationship remains clear and equitable. While I can—and do— feel personally sympathetic to issues that can arise, please consider your booking like a concert ticket. Feel free to use it or not, as supports your best interests at the time. Double sessions require 48 hours notice for the first session and 24 hours as usual for the second.

8. Please understand that you are responsible for payment for services at the time of the appointment (unless prior arrangements have been made).

9. If at any point you have questions about any aspect of your therapy, please ask.

10. CLIENT SIGNATURE, ACKNOWLEDGMENT, AGREEMENT, AND CONSENT

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all terms discussed in this disclosure statement. By signing this disclosure, I also agree to permit consultation and I provide release for my therapist to seek consultation with other psychotherapists or professionals as the need arises.

Client Signature

Date

Therapist Signature

Date

Guardian Signature

Date

DAVID DELANEY . MA, CAR, LPC, Psychotherapist- Individuals & Couples

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303-449-2004 VM- 303-815-3160 Direct-

david@davidgclancy.com

www.davidgclancy.com

CLIENT NAME: _____ **DATE OF BIRTH** _____

ADDRESS _____ **CITY** _____

STATE _____ **ZIP** _____ **PHONE: (H)** _____

(W) _____ **CELL** _____ **EMAIL** _____

BEST TIME(S) TO CALL _____ **OK TO ID?** _____

HOW REFERRED? _____ **TODAY'S DATE** _____

WHY DID YOU MAKE THIS APPOINTMENT? _____

WHAT WOULD BE YOUR FOCUS FOR THERAPY? _____

CURRENT STRESSORS _____

PREVIOUS THERAPY? _____

WHEN/HOW LONG _____

CURRENT MEDICAL ISSUES _____

NAME OF DR./PSYCHIATRIST _____

CURRENT/ PAST DRUG/ALCOHOL USE _____

SUBSTANCE USE IN FAMILY GROWING UP? _____

PRESCRIBED MEDICATIONS? _____

ANY SUICIDAL THOUGHTS: PAST/PRESENT _____