Jessica Grant, LCSW, LLC
Licensed Clinical Social Worker
736 Whalers Way, Suite G 200, Fort Collins, CO 80525

This statement outlines policies concerning my practice and clarifies your rights as a client. Please feel free to ask any questions or to discuss this information at any time.

CREDENTIALS: I hold two Masters Degrees from the University of Illinois, Urbana Champaign: Marriage & Family Services (MS) and Social Work (MSW). I completed a Social Work internship and a post-masters fellowship at Colorado State University Health Network. I am Licensed in the State of Colorado to practice independently (LCSW #09924122). I am a Certified Eye Movement Desensitization and Reprocessing (EMDR) Therapist. Although I share this office with other therapists, each of us works independently, and each alone is responsible for the quality of the care he or she provides Currently I offer a variety of therapies including EMDR (Eye Movement Desensitization and Reprocessing), individual, couples and family therapy.

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Social Work Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894- 7800. The regulatory requirements for mental health professionals provide that a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, but is not licensed or certified, and no degree, training or experience is required.

TIME: Therapy appointments are typically 50 minutes, though they may be longer as necessary. Frequency of appointments is typically once a week, or once every two weeks, though that is determined by your treatment goals, scheduling availability and finances. In the first session, I usually discuss this and develop a plan, which takes these factors into account.

FEES: Fees will be discussed in your first session and payment is due at the time of service unless otherwise agreed. In general, per session fees for 50 minute sessions are

$120. Fees for longer sessions are prorated. Arrangements to bill your insurance company will be discussed in the first session; I am out of network for most insurance plans but can provide you with Superbills to submit to your insurance carrier. If you have an unpaid balance of over six months, your account may be turned over to a collection agency or to small claims court. I am not a Medicare or Medicaid beneficiary. I do reserve a sliding scale fee for clients who have extreme need. Please talk to me about this in your first session if this is a need you have.

CANCELLATIONS: I request that you give 24 hours notice if you need to cancel an appointment. Otherwise, except in cases of personal emergency, sudden onset illness or inclement weather, you will be charged for the reserved time. Insurance companies will not reimburse you for missed appointments. Cancellations may be left with my voicemail at any time (970-556-3063).

MESSAGES: You may use my confidential voicemail (970-556-3063) for messages at any time. I check for messages on a daily basis during the week and return calls by the next day, with the exception of weekends or if I am out of town. For confidentiality reasons, I do not use email or texts with clients.

EMERGENCIES: As is the case with most outpatient therapists, I am not available at all times. I encourage clients to develop additional support systems and to have access to other individuals and/or agencies in case of emergencies.

Listed below are local emergency telephone numbers should you need them:
Colorado Crisis Support, 494-4200; Walk-in crisis center: 1217 Riverside Dr., Fort Collins Crisis Assessment Center at Poudre Valley Hospital, 495-8090;
Or, call 911 or go to the nearest hospital emergency room.

When I am out of town, another therapist covers my practice for me during business hours Monday through Friday. That person's name and phone number will be provided in my voicemail message during the time when I am gone. *Signing this agreement authorizes disclosure of pertinent information about you as needed to the covering therapist.*

CONFIDENTIALITY: Both professional ethics (as stated by the National Association of Social Workers) and the Colorado State Mental Health Code-CRS 112.43.214 (1) (d) require that your privacy be carefully protected. 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. The exceptions to this rule are listed in section 12-43-218 of the Colorado Revised Statutes and the Notice of Privacy Rights you were provided and summarized below:

1. (1) if you sign a release of information form that allows me to disclose information to individuals or institutions specified by you;
2. (2) if you are using insurance benefits, I may disclose relevant information regarding diagnosis and treatment if requested by your insurance company;

3. (3) if you feel that you are in danger of causing immediate harm to yourself or another person, I am required by law to report this to appropriate authorities;
4. (4) if I am ordered by a court of law to disclose information about you (e.g., if I am served with a legitimate subpoena), I am required in some cases to respond to that order;
5. (5) if you reveal information concerning physical or sexual abuse of a child, I am required by law to report this knowledge to the appropriate authorities;
6. (6) if you are in therapy by order of a court of law;
7. (7) if you are involved in a criminal or delinquency proceeding;
8. (8) if I need to provide another therapist with pertinent information when that therapist is on-call for my practice in my absence, or if, on rare occasion, I consult with another colleague about your treatment.

MANDATORY DISCLOSURE STATEMENT: CLIENT RIGHTS

The practice of licensed counselors, psychologists, social workers or marriage and family therapists is regulated by the Board of Regulatory Agencies of the state of Colorado. Their address and phone are:
Colorado State Grievance Board 1560 Broadway, Suite 1340
Denver, CO 80202 (303) 894-7766

All clients are entitled to receive information about any methods of therapy, techniques used, procedures, expected outcomes, and anticipated duration of therapy and the fee structure. Any client may, at any time during the course of therapy, seek a second opinion from another therapist. Furthermore, the client is entitled to terminate therapy at any time. Sexual intimacy between client and therapist during the course of the client's therapy is never appropriate and should be reported to the Grievance Board.
All information obtained during treatment is strictly confidential except as outlined in this policy statement under "Confidentiality."

TREATMENT AGREEMENT

I have read the Mandatory Disclosure Statement provided by Jessica Grant, LCSW, and she has reviewed this information verbally. I understand my rights as a client or as the client's responsible party.
My signature below indicates my understanding and agreement to these policies and procedures.

_____ Print Client Name

_____Client/Responsible Party's Signature

_____ Date

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