

Jennifer Ritchie-Goodline, Psy.D.

Licensed Clinical Psychologist



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Information, Disclosure & Consent

Welcome to my practice. I appreciate the opportunity to provide you with psychological services and look forward to helping you reach your goals. This document contains important information about my professional services and business policies and is provided to you in compliance with Colorado State Law. If you have any questions about the information contained in this document, please ask and I will be happy to answer them for you.

Credentials

I am a licensed psychologist in the state of Colorado. My license number is 2741. I hold the following degrees:

B.A. in Psychology from the State University of New York at Albany, 1992

M.A. in Counseling and Guidance from New York University, 1994

M.A. in Clinical Psychology from the University of Denver, 1999

Psy.D. in Clinical Psychology from the University of Denver, 2000

Additionally, I completed my internship in Clinical Psychology in August 2000 at the University of Denver Counseling and Behavioral Health Center.

Client Rights

- ❖ You are entitled to receive information from me about my methods of therapy, the techniques I use, the estimated duration of your therapy, and my professional fees.
- ❖ You are free to seek a second opinion from another therapist or to terminate therapy at any time.
- ❖ In a professional relationship such as ours, sexual intimacy between a therapist and client is never appropriate. Such a violation should be reported to the State Grievance Board. The Colorado Department of Regulatory Agencies (DORA) has the general responsibility of regulating the practice of licensed and unlicensed psychotherapy practitioners. The State Grievance Board is part of this system. You may contact the State Grievance Board at 1560 Broadway, Suite 1340, Denver, Colorado, 80202, or by phone at 303.894.7766.
- ❖ Generally speaking, the information provided by a client during therapy sessions is legally confidential. A written release of information with your signature is required in order for me to release or obtain information regarding your treatment. However, there are important exceptions to this general rule of confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218) and include criminal or delinquency proceedings, serious danger to self and/or others, grave disability, and instances of suspected child and/or elder neglect and/or abuse.

Treatment Philosophy

I utilize an integrative, individualized treatment approach, drawing from cognitive-behavioral, solution-focused, systems, and feminist theories. As such, I believe in providing goal-directed treatment. This means that we develop a treatment goal or several goals together, after a thorough assessment. All treatment is then planned around progressing toward the achievement of the established treatment goal(s). If you ever have questions about the nature of treatment or anything else about your care, please don't hesitate to ask.

Financial Terms/Fee Information

My standard fee is \$125 per session. Sessions are generally 45-50 minutes long. Payment is due at the time services are rendered. Most major credit/debit cards [Visa, MasterCard, Discover], cash and checks are accepted for payment. There will be a \$25 charge for all checks returned due to insufficient funds. If you have insurance coverage for mental health services and I am a participating provider of your insurance health plan, upon verification of health plan/insurance coverage, your insurance will be billed for you and I will be paid directly by the insurance carrier. You will be responsible for any applicable deductibles and co-payments. Co-payments must be paid at the time services are rendered. If you are not eligible at the time services are rendered, you are responsible for payment in full. If you have insurance coverage for mental health services and I am not a participating provider of your insurance health plan, you will need to check with your carrier about how to file a claim. I will be happy to provide documentation of billing and payments as an out-of-network provider for your insurance needs.

Cancelled/Missed Appointments

A scheduled appointment means that time is reserved only for you. If you are unable to keep a scheduled appointment, please notify me as soon as possible. If an appointment is missed or cancelled with less than twenty-four hours notice, you will be billed directly according to the standard session fee or according to the rules of your health plan. Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment in full.

Late Arrivals

Sessions of late arrivals will end on time and be billed at the standard session rate.

Telephone Calls

If you need to speak with me between scheduled appointments, please leave a voicemail message and I will return your call as soon as possible. I do not charge for brief telephone conversations. However, any telephone call that goes beyond ten minutes will be billed on a prorated basis based on the standard session fee.

Emergency Procedures

If you experience a clinical emergency, please follow the emergency contact procedure outlined on my voicemail message, and I will return your call within an hour. *Please do this for true emergencies only.* In a life threatening emergency, please call 911 or go to the nearest emergency room.

Release of Information

I authorize the release of information regarding my treatment to my health plan/insurance carrier for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan.

Consent for Treatment

I further authorize and request that my treatment provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

Consent

I have read and been advised of my rights and responsibilities as a client. I understand and agree to all of the above information. A copy of this information has been given to me for my records.

Client (or Guardian) Signature Date

Client (or Guardian) Printed Name Date

Jennifer Ritchie-Goodline, Psy.D. Date