Restoration Counseling, LLC
Sheldon McGuire, LMFT
6455 N Union Blvd Suite 200
Colorado Springs, CO 80918
719-761-3217
sheldon@restorationcounselingcs.com www.restorationcounselingcs.com

I am a well-qualified therapist with more than 16 years of experience as a therapist working with diverse populations. I have been very successful in addressing parent/child conflict as well as reaching those adolescents who are otherwise difficult to reach. While my primary expertise is in dealing with adolescent boys, I am also well-equipped to deal with the family as a whole. I am an SOMB (Sex Offender Management Board) qualified provider and have extensively worked with juvenile offenders. I have experience working with their families and training on informed supervision. I also have worked with youth expressing mild to severe depression symptoms. ADHD and oppositional behavior can be addressed as well. I am trained in Cognitive Behavioral (CBT) and Solution Focused Brief (SFBT) Therapy Modalities.

DISCLOSURE STATEMENT & POLICIES

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. Restoration Counseling, LLC ("RC") is located at 6455 N Union Blvd., Suite 200, Colorado Springs, CO 80918, 719-761-3217 The mental health professional located at RC is Sheldon McGuire, LMFT. Sheldon earned his Bachelor of Science in Physical Science from Colorado State University in 1998. Sheldon McGuire obtained his Master of Science in Counseling, Marriage, Family and Child Therapy from University of Phoenix in 2008. Sheldon McGuire is a Licensed Marriage and Family Therapist in the State of Colorado, License No. 0001084.

2. Everyone twelve (12) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for his or her minor child/ren, must sign this disclosure statement on behalf of his or her minor child under the age of twelve (12) years old. This disclosure statement contains the policies and procedures of RC and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

3. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists, Licensed Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified and Licensed Addiction Counselors, and registered individuals who practice psychotherapy. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Licensed Professional Counselor Examiners regulates Licensed Professional Counselors and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through RC's internal process.

4. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your therapist.

5. Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. Licensed Social Worker must hold a master's degree in social work. 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. Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in his or her 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. Registered Psychotherapist is a psychotherapist listed in Colorado's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. Registered psychotherapists are required to take the jurisprudence exam.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

As a client 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. Please ask if you would like to receive this information.

Fees:

1. My fee structure, services, and fee policy are outlined as follows:

   a. $125.00 per hour

   b. It is the policy of my practice to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collection agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

   c. Therapy fees and treatment are based on a 45-50 minute clinical hour instead of a 60 minute clock hour so that I may review my notes and assessments on your behalf.

   d. I **am** a Medicaid provider. If you have Medicaid coverage that includes mental health services, I **am** able to offer mental health services to you.

   e. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services,

testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $420.00 per hour.

Restrictions on Uses:
2. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however RC is not required to agree to a restriction request. Please review RC's Notice of Privacy Policies for more information.

Second Opinion and Termination:
3. You are entitled to seek a second opinion from another therapist or terminate therapy at any time.

Sexual Intimacy:
4. In a professional relationship (such as psychotherapy), sexual intimacy between a psychotherapist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Licensed Professional Counselor Examiners.

Confidentiality:
5. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the psychotherapist is a Licensed Psychologist, Licensed Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Certified and Licensed Addiction Counselor, or a Registered Psychotherapist. If the information is legally confidential, the psychotherapist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

6. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during treatment or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, I may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out RC's Consent for Communication of Protected Health Information by Unsecure Transmissions.

"No Secrets" Policy:
7. When treating a couple or a family, the couple or family is considered to be the client. At times, it may be necessary to have a private session with an individual member of that couple or family. There may also be times when an individual member of the couple or family chooses to share information in a different manner that does not include other members of the couple or family (i.e on a telephone call, via email, or via private conversation). In general, what is said in these individual conversations is considered confidential and will not be disclosed to any third party unless your therapist is required to do so by law. However, in the event that you disclose information that

is directly related to the treatment of the couple or family it may be necessary to share that information with the other members of the couple or the family in order to facilitate the therapeutic process. Your therapist will use his best judgment as to whether, when, and to what extent such disclosures will be made. If appropriate, your therapist will first give the individual the opportunity to make the disclosure themselves. This "no secrets" policy is intended to allow your therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the couple or the family being treated. If you feel it necessary to talk about matters that you do not wish to have disclosed, you should consult with a separate therapist who can treat you individually.

Extraordinary Events:
8. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Four Feathers Counseling
ADDRESS: 332 W Bijou St Suite 103 Colorado Springs, CO 80905
TEL: 855-332-4436

The purpose of the Mental Health Professional Designee is to continue your care and treatment with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for therapy services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Maintenance of Client Records:
9. As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of Marriage and Family Therapist Examiners, RC will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, etc.) for a period of seven (7) years after the termination of therapy or the date of our last contact, whichever is later. RC cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records:
10. RC may keep and store client information electronically on RC's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, RC may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. RC may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

RC may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. RC uses a cloud-based service for storing or backing up information. The cloud-based backup system RC uses is: TheraNest and the email service provider RC uses is: G Suites by Google. RC may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information RC has employed the following security measures:

- Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.
- The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures RC employs, please ask.

Alternative Treatment Modalities:
11. My therapist may offer to employ alternative treatment modalities and therapeutic methods that he deems to be the most beneficial to my treatment. My therapist is trained and qualified to provide these alternative treatment methods and will have me sign an additional consent form, specific to each modality prior to implementing them in my treatment. I understand that I retain the right to consent to incorporating these modalities in my treatment and I may retract my consent at any point in time.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that RC may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with RC's Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in RC's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.

3. I understand that there may be times when my therapist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me in therapy. My confidentiality is still protected during consultation by my therapist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my therapist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my therapist.

4. I understand that, in general, RC does not provide Teletherapy, such as therapy over telephone or video chat. I understand that communications via email and text should be limited to administrative purposes and not used as an avenue for therapy. I understand that should I want Teletherapy, I will discuss my request with my therapist. I understand that it is in my therapist's sole discretion whether to accommodate my request for Teletherapy.

5. I understand that my therapist, does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that RC has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" RC's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on RC's page/wall as well. I understand that any comments I post regarding therapeutic work between my therapist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. I agree that if I have a therapeutic comment and/or question that I will contact my therapist through the mode I consented to and **not** through social media.

6. I understand that if I have any questions regarding social media, review websites, or search engines in connection to my therapeutic relationship, I will immediately contact my therapist and address those questions.

7. I understand my therapist provides non-emergency therapeutic services **by scheduled appointment only**. If, for any reason, I am unable to contact my therapist by the telephone number provided to me, 719-761-3217, and I am

having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. RC does not provide after-hours service without an appointment. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due**. I understand that if I leave a voicemail for my therapist on the phone number provided, my therapist will return my call by the end of the next business day, excluding holidays and weekends.

8. If my therapist believes my therapeutic issues are above his level of competence or outside of his scope of practice, my therapist is legally required to refer, terminate, or consult.

9. **I understand that I am legally responsible for payment for my therapy services. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my therapist to communicate with my insurance company, HMO, third-party payer, collection agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my therapist's entire client file. I understand that once my insurance company receives the information I or my therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my therapist a copy of any report RC submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.**

Medicaid Providers:
10. Health First Colorado Member Billing Providers agree to accept the Health First Colorado payment as payment in full for benefits. Colorado law (C. R. S. 25.5-4-301 (II)) provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Health First Colorado. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service. This law also prohibits providers from billing Health First Colorado members for the estates of deceased Health First Colorado members for Health First Colorado benefits. As such, Health First Colorado members are not responsible for payment for late cancellations or failure to show for an appointment.

11. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

12. I understand that if I have any questions about my therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. By signing this disclosure statement, I also give permission for the inclusion of my partners, spouses, significant others, parents, legal guardians, or other family members in therapy when deemed necessary by myself or my therapist. I agree that these parties will have to **sign a separate Consent for Third-Party Participation Agreement** or may have to sign a separate disclosure statement in order to participate in therapy.

13. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with RC or my therapist, my treatment will be considered "terminated." I may be able to resume therapy after the sixty (60) day period by discussing my decision to resume therapy services with RC. Ability to resume therapy after sixty (60) days will depend upon my therapist's availability and will be within his sole discretion. This disclosure statement will remain in effect should I resume therapy if one (1) year has not elapsed since my last session. However, I may be asked to provide additional information to update my client record. I understand "discontinuing therapy" means that I have not had a session with my therapist for at least sixty (60) days, unless otherwise agreed to

in writing.

14. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients.

15. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of therapist and client. This means that my therapist cannot be my friend, cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of counselor to his relatives, friends, the relatives of friends, people known socially, or business contacts.

16. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.

17. I also affirm, by signing this form, I am at least twelve (12) years old and consent to treatment and therapy services here at RC or that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of twelve (12), for whom I am requesting therapy services here at RC.

18. I understand that if I am consenting to treatment and therapy services for my minor child/ren that my therapist will request that I produce, in advance of commencing services with RC, the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to mental health services for my minor child and make therapeutic decisions on behalf of my minor child/ren. Further, I understand and agree to keep my therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my therapist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

19. By signing this form, I affirm that I am fully informed of the therapy services I am requesting, and that RC is providing, and grant my consent to receive such therapy services.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

Client Name/Signature	DATE
Parent/Legal Guardian Signature (Please specify Relationship to Client)	DATE
Parent/Legal Guardian Signature (Please specify Relationship to Client)	DATE
Sheldon McGuire, LMFT (Therapist Signature)	DATE