Amie R. Bryant, LCSW, CAC III
Four Corners Counseling, LLC

DISCLOSURE STATEMENT

Practice
Amie R. Bryant
Four Corners Counseling, LLC
2243 Main Ave, Suite 4A
Durango, CO 81301
970-946-8004

Degrees
University of Denver, MSW, 2006
Ithaca College, BA, 1998

Licenses
Licensed Clinical Social Worker,
State of Colorado, license #1118
Certified Addictions Counselor III,
State of Colorado, license #7150

The practice of both licensed and unlicensed psychotherapists is regulated by the Department of Regulatory Agencies under CRS 12.43.214 (1)(c). Questions or complaints may be addressed to the Colorado Department of Regulatory Agencies, Board of Social Work Examiners, 1560 Broadway, Suite 1350, Denver, CO 80202, (303) 894-7800.

As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, must hold a masters degree in their profession and have two years of post-masters supervision. A Certified Addictions Counselor III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience.

Client Rights and Important Information

Under the Colorado Mental Health Practice Statute 12.43.214, you are entitled to receive information from me about my methods of clinical work, the techniques used, the duration of clinical work (if known), and my fee structure. You may seek a second opinion from another licensed or registered mental health professional or you may terminate our work at any time. Designated client records may not be maintained after 7 years of termination of treatment. In a professional relationship (such as ours), sexual intimacy is inappropriate and should be reported to the Board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

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 Statutes, in the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. Confidentiality is further discussed in my Practice Policies and Procedures.

If you have any questions or would like additional information, please feel free to ask.

I have read and discussed the preceding information, and understand my rights as a client or as the client's responsible party.

____
Client Name

____
Signature Date

____
Guardian/Personal Representative Name (if applicable)

____
Signature Date

____
Relationship to Client

Amie R. Bryant, LCSW, CAC III
Four Corners Counseling, LLC

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY RIGHTS & PRACTICE POLICIES/PROCEDURES

I, ________________________________, acknowledge that I have read the Disclosure Statement and that I have received
(Client Name)

a copy of the Notice of Privacy Practices and the Practice Policies/Procedures for Four Corners Counseling, LLC.

____ ________________________
Signature of Client/Guardian/Personal Representative Name Date

____
If not the client, please print name and state legal authority to sign for client

--*For Practitioner Use Only*---

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices and Practice Policies/Procedures but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining acknowledgement
Client was incapable of signing
Other (specify)____

____ ________________________
Signature of Practitioner Date

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ELECTRONIC FORMS OF COMMUNICATION
INFORMED CONSENT

I/we, ____, understand that electronic forms of communication such as email, text, etc., cannot be considered confidential. As such, I understand that if I use and/or agree to allow this practice to use such forms to communicate with me, there is a chance that the dialog may not be private. I understand that this practice takes precautions to ensure that all communication is confidential, but it cannot be assured with these forms of communication.

Communication Options (please choose all that apply):

- I agree to communicate by text for scheduling/appointment reminders only
- I agree to communicate by text for all details of treatment
- I agree to communicate by email for scheduling/appointment reminders only
- I agree to communicate by email for all details of treatment
- I agree to receive billing communication by email
- I prefer to communicate by telephone/postal mail only

My preferred method for appointment reminders is: text email no appointment reminders

If you have further question, please speak to me directly. These choices will remain in effect unless they are changed in writing.

____ Signature

Date ________________________