BLUE MOON COUNSELING
Play, Music, & Family Therapy

Disclosure Statement

Colorado Law requires that the following information be provided to all clients.

Clinician: Michelle Chrastil Ma LPC
Licence Type: Licenced Profession Counselor
Edcuation: MA in Counseling Psychology and Counselor Education from CU Fall 2008
BA in Human Development and Family Studies from CSU Sprin 2004
Blue Moon Counseling "Play, Music & Family Therapy"
Email: Michelle@bluemooncounseling.com
Cell: 303-669-0893 Fax: (303) 455-0420

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, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is:

Department of Regulatory Agencies
Mental Health Section
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7766

If there are any complaints or concerns regarding the practice of mental health, please direct them to the above listed department.

A separate addendum to this disclosure, which identifies your therapist's training and license, will be provided to you.

You are entitled to receive information from me regarding methods, techniques, fee structure and duration (if known) of the sessions. You have the right to seek a second opinion from another therapist or terminate therapy at any time.

The information provided by you during counseling is legally confidential except as required by law and is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. There are exceptions to the rule of confidentiality that can be explained and will be identified to you should any situations arise during therapy. Some of these exceptions are listed in section 12-43-218 and in the Notice of Privacy Rights you were provided. In general, the exceptions include a "threat of serious harm to yourself or others" as in the case of child abuse, suicide, grave disability; under a court order; or in response to any legal

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action taken by you against this agency. You should also be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

You should know that supervisors and other therapists detailed on the attached addendum may provide supervision and/or consultation to each other. As such information regarding your case may be made available to staff and contractors of Healing Connections Counseling as is warranted for administrative and/or clinical care coordination.

As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters 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 masters 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 1000 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 bachelors 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 masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required. However the registered psychotherapist is listed in the State'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.

I understand I am responsible for all fees agreed to in the financial agreement. Fees are due upon receipt of services, and should billing attempts fail, delinquent accounts will be turned over to a collection agency.

I have been informed of my therapist's degrees, credentials and licenses. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client/patient.

☐ I, _____, have received a copy of Michelle Chrastil Counseling LLC DBA Blue Moon Counseling's Notice of Privacy Practices.

_____ _____

Signature of client Date Therapist Date
(Parent or Guardian for a minor)

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Group Therapy Agreement

As a participating member in group therapy you are hereby agreeing to the following group therapy expectations. In the case that you violate on of these guidelines I reserve the right to discuss with you my concerns and may terminate your therapy with providing a proper referral.
Please sign initials indicating group participation/interest.

_____Women in Transition Therapy Group therapy costs range from $40 per group session with a paid commitment of $200.00 for 5 sessions. Group members may recommit to group every five weeks and their credit card will be charged the $200 every 5 weeks. At least 14 days notice is required when a client decides to end their participation in group at the end of their 5 week session.

_____Living with Chronic Illness Rehabilitation Group is a group designed to support individuals with chronic illness or pain. Goals include rehabilitation into community by decreasing isolation, improving ability to communicate feelings and needs, create support and meet individual goals through a group setting.

_____Children and Family Rehabilitation Groups are offered monthly to include Equine Assisted therapy with horses, Music Therapy, Holiday events, and in community social skills building groups. This is a Medicaid funded service and private pay options for Equine Assisted Therapy are available at $90 per hour session.

_____Equine Assisted Therapy groups for Couples and Families are also offered at $180 per couple, Medicaid funded or $180 per family up to 4 members.

_____ Children Social Skills groups are offered on a monthly or bi-weekly basis and are $40 per group with a five week minimum commitment. Medicaid is also a payer for this service. These groups may take place at one of our office locations or in the community.

Group Therapy Disclosure and Agreement:

I ,_____,Parent of client or Participating Client, sign this Release of Information, to disclose that myself or a family member has participated in counseling services with Michelle Chrastil Counseling, LLC dba Blue Moon Counseling.

I, _____, agree and understand that this group therapist will be integrating my individual therapy goals into this group therapy treatment model.

I, _____, agree to respect a level of confidentiality within the group. All materials discussed must remain confidential.

I, _____(Initals) agree to make every effort to attend all scheduled group therapy sessions. In the case that an emergency comes up the group member will contact the therapist within 24 hours of the next scheduled session. The therapist reserves the right to waive the group fee but on most instances the group's fee will be due

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regardless of attendance.
_____(initials) In the situation where a group member decides to withdrawal from the group, an individual meeting needs to be set up with the therapist to discuss the most appropriate way to withdrawal from the group.

_____(Initals) In the situation where I may have a complaint with another member of the group or with the therapist, I agree to discuss these concerns with the therapist by phone. Therapist offers 15 minutes of phone consultation free of charge in this instance but an individual session should be scheduled if client requires more of the therapist's time to resolve this issue. Text message complaints are never appropriate in this situation.

Signature of Client/Guardian of Client:

Client Name: _____Date: _____

Payment Information
Name (First, Last, Birthdate):_____DOB____/____/_____
Address: _____
_____
Phone #:_____
Emergency Contact: _____Phone Number: _____
Email: _____

Credit Card: Visa, Mastercard, AA
Credit Card #:_____
Expiration: _____
CVC: _____
Zipcode: _____

Emergency Procedures
If you need to contact me, leave me a detailed message and your call will be returned, typically within 24 hours. In the case of an emergency, indicate that your call is an emergency but please do this in the case of true emergencies. In most cases, I would encourage you to call 911 or to go directly to your nearest Emergency Room if you truly believe the situation to be an emergency.

Please contact me by leaving a detailed message on my work cell phone at #303-669-0893 for all non emergencies. I often use text messages to send appointment reminders or changes in appointment time availability if you agree to this use of communication. Clients may also use text if you need to cancel or reschedule an appointment and are doing so within 24 hours of your scheduled appointment.

Please Do Not use text message to communicate with me on any other matters. If you have a question or concern or just need to talk, please call me on my work cell phone. If this boundary is violated, I do reserve the right to terminate our sessions and provide you with an alternative therapist referral.

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Grievance Board
The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of of unlicensed and licensed psychotherapists. Sexual intimacy between client and therapist is illegal in Colorado and should be reported to the Grievance Board.
You may contact the State Grievance Board at 303-894-7766 or at
1560 Broadway, Suite 1340 Denver, Colorado 80202

If you have any questions or would like additional information, please feel free to ask.
I have read the preceding information and understand my rights as a client.

Please Initial The Documents You Have Reviewed and Signed Prior to Treatment

1. Disclosure Form: _____
2. Financial Disclosure Form: _____
3. Hippa Compliance: _____
4. Group Therapy Agreement: _____
5. Release of Information: _____

Client Name: _____

Client Signature: _____ Date: _____

Therapist/Witness: _____ Date: _____

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FEE AGREEMENT

I understand that unless another payment schedule is specifically arranged, the following fee agreement applies: The charge for individual, couple, and family psychotherapy is $120.00 per 55-minute session or $180.00 per 90-minute session Couples or Family Therapy session. The fee for group psychotherapy is $200.00 for 5 sessions or $20.00 per group for members on disability.

PAYMENT AGREEMENT
I understand that if I am paying privately I will pay for all services provided either for myself or for my designee, (name) _____, (relationship) _____, at the conclusion of each session on the day the services are provided.

I understand that if I am not able to honor my financial commitment that this may be grounds for conversing therapeutically about financial issues, renegotiating my therapeutic contract, exploring alternative options, and/or terminating from treatment.

I understand that if I am not able to make a payment after a particular session that I may ask my therapist for an extension for another week. I agree to make every effort to remit payment within that time frame. I also understand that I may not have more than two unpaid sessions accumulated at any one time. If this should happen I understand that I will need to speak with my therapist in order to negotiate the next steps.

I understand that I may pay with cash, personal checks, or money orders, however, should my personal check be returned due to insufficient funds, I will be assessed a $20.00 service charge and I will be requested to pay with cash, or money order thereafter. I realize that while my signature does not bind me to therapy, it does make me responsible for all charges incurred prior to my termination.

Finally, I release People House and my therapist from all liability for providing to a Collection Agency any information necessary to collect fees due if my account becomes delinquent and that should this happen, the cost for collection will become my responsibility.

MISSED SESSION POLICY
I understand that unless otherwise prohibited, I will be charged my full fee for any missed appointments or appointments canceled with less than 24 hours notice without just cause (i.e. an emergency, inclement weather, or other unpredictable situation). I further understand that most third party payment sources do not pay for missed sessions and thus I am solely responsible for these fees.

LIMITATIONS OF CONFIDENTIALITY
I understand that if I am providing payment for a non-minor designee, I may not have legal access to any kind of privileged information about that individual including assessment information, diagnostic information, or therapeutic progress. By contrast, I do understand that if another party, such as victims compensation, is providing payment for my therapeutic services, I authorize that individual or institution to be informed of my presence in treatment, details of my diagnoses and care, and/or my discharge from treatment. I also understand that there are further limitations to confidentiality discussed in the Client Disclosure Statement or other agreements and am aware of these constraints.

USING THIRD PARTY PAYMENT SOURCE

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I understand that if I am using a third party payment source that I authorize People House to release and/or exchange any pertinent information with such entities in order to utilize these benefits. This information includes but is not limited to my presence in treatment, my progress in treatment, my psychiatric diagnosis, any assessment information, and my discharge plan.

In addition, I also agree to pay my designated co-pay and to promptly and consistently communicate with such entities if my situation should change in order to ensure that my coverage is continuous. I understand that most third party payment sources, do not pay for missed sessions and thus I am solely responsible for these fees. I further recognize that it is my responsibility to obtain any pertinent information to utilize third party benefits such as:

- Types and amounts of coverage.
- The types of forms or paperwork that I, or my therapist, need to complete and/or remit in order to receive reimbursement.

REVISIONS TO FEE SCHEDULE
$_________ Fee for Individual Psychotherapy, Couple, or Family Therapy
$_________ Fee for Group Psychotherapy
$_________ Medicaid or Waiver Insurance: ____

Client/I have read the preceding information and I agree to the aforementioned terms:

Client Name: ____

Client Signature: ____________________________________ Date: ___________________

Therapist/Witness: ____________________________________ Date: ___________________

- -

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Demographics Intake

Today's Date:_____
Client's Birthday:_____
Client's Name (First, Last, Middle) _____
Home Address: _____
Medicaid #:_____
Phone Number:_____-_____-_____
Emergency Contacts Phone Number/Name: _____
Primary Guardian's First and Last Name: _____
_____

Reason for Beginning Therapy:
_____
_____
_____

Current Therapy Goals (client)
Therapy:_____
_____
_____

How would you know that therapy was helpful to you if you look back after the experience?
_____
_____
_____

On a scale of 1-10 please rate the following related to Client.
(1 represents the lowest amount of disturbance and 10 represent the highest amount...)
Depression: _____
Anxiety: _____
Current Level of Suicidal ideation: ____
Rate your overall level of satisfaction in life: _____

Please list any history of family members with previous mental health diagnosis:
_____
_____
_____
_____

Please list any Prescription Medications: (Include Dosage and Duration)
_____
_____
_____

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Please describe the most concerning behaviors or symptoms (Client) has experienced in the last 3 months?_____
_____
_____
_____
_____

What would you say is the biggest reason in your opinion (client) has been struggling? Please list any recent triggers?
_____
_____
_____
_____

Please List any Physical, Emotional, Sexual, or Psychological Abuse that may be relevant to Client. Also any hx of abuse related to primary family members.
_____
_____
_____

Are you seeking counseling related to a medical condition, chronic illness, or chronic pain? Circle (Yes or No)
If yes what year were you first debilitated by your medical symptoms?_____
Which symptoms were the most challenging during the beginning stages of your illness?_____
_____
_____
_____
Which symptoms are bothering you most now?_____
_____
_____
Do you have a current diagnosis for your illness and if so please list here:
_____
_____
_____
_____
How could either individual or group therapy be most helpful to you at this time?_____
_____
_____
Have you had previous positive or negative experiences with counseling? If so please describe what was helpful or hurtful in your opinion:_____
_____

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Notice of Privacy Practices

Effective Date: April 14, 2003
PLEASE REVIEW CARFULLY
Overview: The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (DHHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.

I. What is "medical information?"

The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by a health care provider (me), health plan or other and relates to the past, present or future physical or mental health or condition of an individual (you); and the provision of health care (e.g. mental health) to an individual (you); or the past, present or future payment for the provision of health care to an individual (you).

I am a mental health care provider and I create and maintain treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records" or "mental health records" and this notice among other things concerns the privacy and confidentially of those records and the information contained therein.

II. Uses and Disclosures Not requiring the Client's Consent

A. Treatment- Treatment refers to the provision, coordination or management of health care (including mental health care) and related services by one or more health care providers. For example, Caring Heart Counseling staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

B. Payment- Payment refers to the activities undertaken by a health care provider (including a mental health provider) to obtain or provide reimbursement for the provision of health care. If you health plan requests a copy of your health records or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy or contract, I am permitted to use and disclose your personal health information.

C. Health Care Options-Health Care Operations refers to activities undertaken by Caring Heart Counseling that are regular functions of the management and administrative activities. For example, Caring Heart Counseling may use your health information in monitoring service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning and accreditation, certification, licensing and credentialing activities.

D. Contacting the client- Counseling may contact you to remind you of appointments and to tell you about treatments and other services that may be of benefit to you.

E. Required by Law- Counseling will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards. Example for audits, civil or criminal investigations, licensure or disciplinary actions. If disclosure if compelled by the US Secretary of Health and Human Services to investigate my compliance with privacy requirements under the federal regulations (the "Privacy Rule")

F. Family Members- Except for certain minors, incompetent clients or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

G. Emergencies- In life threatening emergencies Counseling will disclose information necessary to avoid serious harm or death.

H. Disclosures without your Authorization- Counseling is required to disclose when an arbitrator or arbitration panel or administrative agency pursuant to a subpoena, notice to appear or any provision authorizing discovery in a proceeding before a court or administrative agency. If a search warrant is lawfully issued to a governmental law enforcement agency. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger. If you tell me of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims. If I have reasonable suspicion of child abuse or neglect. If in the event of your death, to the coroner in order to determine the cause of your death.

III. Client Authorization or Release of Information- Counseling may not use or disclose protected health information in any other way without a signed Authorization or Consent to Release Information. When you sign an Authorization or Consent to Release Information, it may later be revoked, provided that the revocation is in writing. The revocation will apply except to the extent Counseling has already taken action in reliance thereon.

IV. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information: You have a right to inspect and obtain a copy of the protected health information Counseling has about you by making a specific request in writing. This right to inspect and copy is not absolute- in other words I am permitted to deny access for specified reasons. For instance, you do not have this right of access with respect to my "psychotherapy notes." The term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical (includes mental health) record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

B. Amendment of your Record- You have the right to amend protected health information in my

records by making a request to do so in writing that provides a reason to support the requested amendment. This right to amend is not absolute, in other words, I am permitted to deny the request amendment for specified reasons. You also have the right, subject to limitations, to provide me with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become part of your record.

C. Accounting of Disclosures- You have the right to receive an accounting of certain disclosures Counseling has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment or health care operations. I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction. In addition the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003.

D. Additional Resources- You have the right to request additional restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health operations. I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction.

E. Alternative Means of Receiving Confidential Communications- You have the right to receive confidential communications of protected health information from me by alternative means or at alternative locations.

F. You have the right to obtain a paper copy of this notice from me upon request.

V. Additional Information

A. Privacy Laws- Counseling is required by State and Federal law to maintain the privacy of protected health information. In addition, Counseling is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice- Counseling is required to abide by the terms of this Notice, or any amended Notice that may follow. Counseling reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in Counseling's office and will be available upon request.

C. Complaints Regarding Privacy Rights- If you believe your privacy rights may have been violated either by me or by those who are employed by Counseling. You may file a complaint with me by simply providing me with a writing that specifies the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful to me. My telephone number is (303) 393-0085. I will not retaliate against you in any way for filing a complaint with me or with the Secretary. Complaints to the Secretary must be filed in writing. A complaint to the Secretary can be sent to the US Department of Health and Human Services, 1961 Stout Street, Room 1426, Denver, Colorado 80294 (303) 844-2024, (303) 844-3439,

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MEDICAID FINANCIAL INFORMATION and CONSENT TO TREAT

Financial Information

_____ Not applicable as funding will be sought from Medicaid.

Appointments

Appointment times are not automatically held open for you from week to week. It is the client's/parents' responsibility to reschedule at the end of a session or to call if you wish to schedule an appointment.

Cancellations

In the event you need to cancel an appointment, please provide notice to me within 24 hours of your scheduled appointment time. If you cancel or miss an appointment without 24 hours prior notice (major emergencies exempted) you will be billed $ _____ for the session. I do work very hard to be flexible with my schedule for clients in crisis or acute need and this, from time to time, may affect a set schedule. If you are using Medicaid to pay for your services (CORE is exempted) and if you do not show up for your appointment or cancel less than 24 hours two times, I reserve the right to discontinue services. If this occurs you will be given a list of other providers from whom you can seek further services.

Telephone Calls

If you need to speak with me between sessions you may call or leave me a voicemail on my secure line. All telephone consults will be billed as case management.

Termination

You may end treatment whenever you choose and you may seek a second opinion if you wish to do so. Treatment will usually have a natural end point. If you are the guardian of a child and services are terminating, please plan to schedule a final session to talk about the child's progress and allow the child and I to say good-bye which models important relationship closure skills.

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CONSENT TO TREAT & Agreement to the above-stated Information

I authorize counseling of the person(s) named. I understand my legal rights. If services are to be billed to a Medicaid Managed Care company, I authorize the release of any medical or other information necessary to process this claim. I further understand that I am liable for charges in the event of a claims denial. I agree to provide any necessary forms or documentation to assist in settling my account. Charges shown by statements, if statements are rendered, are agreed to be correct and reasonable unless protested in writing within thirty days of statement date. Furthermore, I attest that I have read this information form, that I understand the conditions as stated above, and that I consent to therapy, including evaluation, treatment and/or referral.

Clients Name: _____
Client Signature (If Above the age of 15) _____

If under the age of !5 please sign below:

Parent #1
Client/Guardian Signature: _____Date:_____

Parent #2

Client/Guardian Signature:_____Date:_____

Couples Therapy:

Client #1 Name: _____Date: _____

Client #2 Name: _____Date: _____

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Client Grievance Policy and Procedures

Michelle Chrastil Counseling, LLC believes in providing the highest quality services to its clients and consumers. Michelle Chrastil Counseling strongly supports the right of a client, services provider or the legal guardian of a client to file a grievance with regard to services, personnel, policies or procedures. Your concern is the upmost Importance to us and we strive to resolve the issue in a timely manner. In order to maintain our relationship with you we request you follow the steps below. At any point in this process, you have the right to file a grievance with the Colorado Department of Regulatory Agencies. There will be no retaliation against any person filing a grievance.

The following procedure should be followed to express a grievance:

1. The grievance should first be addressed with the Clinician that you have been working with directly.
2. If the grievance is not resolved to your satisfaction, you must put your grievance in writing and send it to the Clinical Director at Blue Moon Counseling. The Clinical Director will maintain a log of grievances and will record the date the complaint was received and all subsequent communications to track compliance with this policy.
3. The Clinical Director will respond no later than 2 days after the grievance has been filed and will start an investigation. This may include scheduling a meeting as soon as possible to discuss the matter for the purpose of resolving the grievance. If there is no resolution of the grievance with the Clinical Director, you may appeal your grievance to the Board of Directors.
4. Within 2 business days, after your meeting with the Clinical Director, your written statement regarding your grievance is to be submitted to the Board of Directors. The Board will respond to you in writing about their recommendations within 10 business days of receiving the grievance.
5. If extenuating circumstances exist which require additional time for resolution, an interim report shall still be provided to you at the 10 day point, with a final report at the conclusion of the investigation. The interim report shall include the reason for the delay and an estimated date, not to exceed 30 days, for completion for the investigation and response.
6. The decision of the Board of Directors will be considered final. If the grievance is not resolved to your satisfaction within the agency or with the Board of Directors, you have the right to contact The Colorado Department of Regulatory Agencies and follow it's procedure for grievance pursuant to Colorado Law. The appropriate licensing body will be given copies of any and all reports and correspondence on the case.
7. 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, licensed school psychologists practicing outside the school setting, and unlicensed individuals who practice psychotherapy. Department of Regulatory Agencies

Mental Health Section
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7766

I have read this policy and agree to complete the steps listed above if I have any concerns, complaints or grievances against Blue Moon Counseling. I understand I have the right to file a grievance with the Department of Regulatory Agencies at any time during this process.

_____	_____
Client or Legal Guardian Printed Name	DOB
_____	_____ ___
Client or Legal Guardian Signature	Date
_____	_____
Clinician Signature	Date

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Treatment Plan and Counseling Contract

Treatment Goals

1.

2.

3.

4.

Therapist Notes:

Counseling Contract: Timeline for client and therapist to meet goals and work towards termination.

I, _____, agree to commit to work on these therapy goals with clinician, _____, for the next _____months. I agree to participate in counseling _____times a week/month. Once this time commitment is complete we will discuss our progress and renegotiate moving forward with an extended period of treatment or will agree to terminate therapy due to goal completion.

Client Printed Name: _____
Client Signature:_____
Date: _____

Clinician Signature/Date: _____

Date to be reviewed: _____