Karen E. Conklin-Johnson, MA, LPC
Marriage Counseling & Individual Therapy

Address: 1556 Williams St, Suite 202, Denver, CO 80218
Phone: 303-909-9488
Email: kcjcounseling@gmail.com
Web: www.kcjcounseling.com

Professional Policies & Agreement

Therapeutic Orientation:
We will discuss this more at length during our initial consultation. In brief, my therapeutic approach is a client-centered psychotherapy. This counseling approach is based on the idea that the potential of a person or persons is realized in a relationship in which the therapist communicates genuineness, caring, and a deeply sensitive, non-judgmental understanding. I work with adult individuals and couples.

Consultation and Confidentiality:
There are several exceptions to my requirement of maintaining confidentiality-- if there is reason for me to believe that you are a potential harm to yourself or others; suspected child abuse, either victim or perpetrator; or if you file a lawsuit against me (per Colorado law your right to confidentiality is waived). At times I may seek consultation from another clinician to ensure that you are receiving the best possible care. A minimum amount of information will be disclosed with all efforts made to maintain your privacy.
I have an administrative person who helps me with bookkeeping and invoicing. She is bound by a confidentiality agreement that she has agreed to and signed. I can provide a copy of this agreement at your request. If I am unable to collect my agreed upon fee, I may send your name and address to a collection agency. Interest may be assessed on the unpaid balance 30 days past due at the rate of 1.5% per month or 18% per year.
Additionally, when I am away from my office for several days, I may ask another licensed therapist to cover emergencies for me. Generally, I will tell this person only what he/she needs to know for an emergency situation.
We may communicate by phone, voicemail, email or text message. I will take all reasonable precautions to maintain your privacy.
Other exceptions to confidentiality may apply. Please reference the relevant Colorado statutes cited in my Mandatory Disclosure if you have further questions.

Fees and Payment Policy:
Payment is due at the beginning or end of each session by check, cash or credit card. I can provide an invoice on a monthly basis if you would like to file with your insurance for out of network mental health benefits. My fee for a 55-minute adult session is $95.00. I also offer longer sessions with fees as follows: $125 for a 75 min. session and $155 for a 90 min. session. Extended sessions must be arranged before our meeting time in order to book my calendar accordingly. My fees may be negotiable, depending upon the specific circumstances of the potential client. The agreed upon session fee for our work is: _____. **Please initial** next to fee amount to indicate agreement.
Any additional requests may be charged at a pro-rated hourly rate including phone conversations lasting more than ten minutes.

(continued on the following page)

Cancellations
I require a 24-hour notice if you need to cancel or reschedule an appointment. This can be done via email or phone. If you cancel within the 24-hour time frame, you are responsible for the payment of the missed session at the above agreed upon rate.

In case of Emergency:
I cannot assume responsibility for my client's day-to-day functioning as an institution, hospital or other agency can. If you feel that you might be in need of after hours care, please discuss this with me during our initial consultation so that I can give you appropriate referrals for the care that you need.
If you experience a counseling emergency please call my voicemail immediately and leave me a detailed voicemail message regarding the nature of the emergency including the phone number where you can be reached. If you feel that you are in immediate danger, please call 911 or go the nearest hospital emergency room.
Please ask any questions if something is unclear about my therapeutic orientation, client consultation and confidentiality, fees and payment policy or emergency care.

I *understand and agree with all of the above-mentioned professional policies. I acknowledge receipt of the Notice of Privacy Practices describing the use and release of my health information and my health information rights. I agree to meet all financial obligations for my counseling with Karen Conklin-Johnson, MA, LPC. I understand that there is no absolute guarantee of a cure in the practice of counseling, and no promises have been made to me regarding the outcome of counseling.*

_____ _____
Client Signature (Parent/Guardian for minor) **Date**

_____ _____
Client Signature (Parent/Guardian for minor) **Date**

_____ _____
Karen E. Conklin-Johnson, MA, LPC **Date**