

Disclosure Statement & Consent to Treatment

Summit Counseling Associates, Inc.
Craig L. Loving, D.Min., LMFT
1481 Russell Way, Thornton, Colorado 80229
303-349-7398
DrCraig@SummitCounselingAssociates.com

I am required by Colorado Law to submit to you my qualifications and legal restrictions under which I practice. Please meet with me ONLY after you have read my qualifications and find them satisfactory. Please sign ONLY after you have read this material and agree with its conditions. If you have any questions, please ask.

Credentials

Licensed Marriage and Family Therapist (#746). State of Colorado, Department of Regulatory Agencies. Division of Registrations, Suite 1575, 1560 Broadway, Denver, CO 80202-5140

Clinical Member American Association of Marriage and Family Therapy. 1123 Fifteenth Street, NW -- Suite 300, Washington, DC 20005-2710

Ordained Pastor: The American Association of Lutheran Churches, 1988. 801 West 106 Street, Suite 203 Minneapolis, MN 55420-5603

Education

Doctor of Ministry (D.Min.). Marriage and Family Counseling. Denver Seminary, Denver, Colorado. 2004.

Master of Divinity (M.Div.). Luther Theological Seminary, St. Paul, Minnesota. 1980.

Bachelor of Arts (BA). Wartburg College, Waverly, Iowa. 1976.

Specialties

Individual, premarital, marital, and family counseling; communication training relationship enrichment, assessment (personality and behavioral) and consultation.

Fees & Policy

[Contact me](#)

1. Unscheduled conversations initiated by the client lasting longer than five minutes are pro-rated at the hourly fee, and billed in 15-minute increments.
2. On occasion, unforeseen circumstances require appointments to be rescheduled. Except in cases of emergencies, 24 hours notice must be given for cancellations and/or rescheduling of appointments.
3. Sessions that are missed for reasons other than an emergency will be billed at the same rate.
4. Payment is requested at the time of service.

IF YOU HAVE ANY QUESTIONS ABOUT THIS POLICY, PLEASE ASK.

YOUR RIGHTS AS A CLIENT

1. 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.
2. You may seek a second opinion from another therapist or terminate therapy at any time. Sometimes therapists and clients do not work well together. If you feel this is the case, please discuss this with me and I will give you the name(s) of other therapist(s) who might serve you more effectively.

During the time we work together, I will discuss your progress and status with you on an ongoing basis. When I see you approaching readiness to leave therapy I will discuss this with you.

3. In a professional relationship such as ours, sexual intimacy between therapist and client is **never** appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board at 1560 Broadway, Suite 1340, Denver, CO 80202 (303) 894-7766.
4. Generally speaking, the client / therapist relationship is legally confidential. Unless you grant specific permission in writing, I cannot disclose to anyone that you are a client or the content of our conversations.

There are exceptions to the general rule of confidentiality. These exceptions are listed in the Colorado statutes (see C.R.S. 12-43-218 in particular).

Ethical exceptions to confidentiality

In marriage and family counseling, it is accepted professional practice that any information shared with the therapist by one party during private sessions may be discussed with all parties involved during conjoint sessions if the therapist believes it might benefit the couple or family. I follow this practice.

Legal exceptions to confidentiality

Colorado statutes provide for important exceptions under which I am **NOT ALLOWED** to keep information confidential. Among them are:

- a) If you are immediately dangerous to yourself, others, or are gravely disabled, and are unable to care for yourself;
 - b) If you disclose that you or another person has physically or sexually abused or molested a child, an incompetent or disabled person.
 - c) If you are involved in a criminal or delinquency proceeding, and I am called by a Court of Law to testify.
5. I consult with other experts about your treatment. By signing this form, you specifically permit me to discuss your case (including session notes, assessment results and other pertinent material) with other licensed professionals for the purposes of consultation.
6. Often people seek therapy to gain relief from painful issues they are experiencing in their lives and relationships. You should know, however, that some people experience increased feelings of distress as they develop new insights into or ways of dealing with their problems. Additionally, some people seek therapy to evaluate the health of their relationships. The decision to marry or to remain married is always the responsibility of the client(s).
7. If in the course of therapy it becomes apparent that your problems may be related to a medical or organic condition, I will refer you to seek care from your medical care provider and / or psychiatrist before I continue additional therapy with you.
8. If in the course of therapy it becomes apparent that we are discussing issues outside my training or experience, I will refer you to other therapists skilled in such issues.
9. IF A MEDICAL DOCTOR HAS PRESCRIBED MEDICATIONS TO HELP YOU WITH MENTAL OR EMOTIONAL PROBLEMS (e.g., BIPOLAR DISORDER, SCHIZOPHRENIA, DEPRESSION, ETC.), YOU AGREE TO CONTINUE TAKING THESE MEDICATIONS AS PRESCRIBED DURING THE TIME WE ARE WORKING TOGETHER. IF YOU REDUCE OR DISCONTINUE TAKING THESE MEDICATIONS WITHOUT THE KNOWLEDGE OR APPROVAL OF YOUR MEDICAL DOCTOR, I WILL CONSIDER THIS A STATEMENT OF YOUR INTENTION TO TERMINATE OUR COUNSELING RELATIONSHIP.

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

By your signature, you acknowledge that you have (a) read the preceding information, (b) understand your rights as a client, and (c) voluntarily enter into a therapeutic relationship with me according to the terms of this statement.

Client Signature

Date

Client Signature

Date

Therapist Signature

Date

Copy for Records

By your signature, you acknowledge that you have (a) read the preceding information, (b) understand your rights as a client, and (c) voluntarily enter into a therapeutic relationship with me according to the terms of this statement.

Client Signature

Date

Client Signature

Date

Therapist Signature

Date

Disclosure Statement & Consent to Treatment

Summit Counseling Associates, Inc.
Craig L. Loving, D.Min., LMFT
1481 Russell Way, Thornton, Colorado 80229
303-349-7398
DrCraig@SummitCounselingAssociates.com