REDWOOD
Counseling Services

www.redwoodcounselingservices.com

Amanda Dwyer, LPC/LAC

7851 S Elati St, Littleton, CO 80120

P: (303) 351-5153 ext. 103 E: adwyer@redwoodcounselingservices.com

DISCLOSURE STATEMENT & POLICIES

Amanda Dwyer is a counselor with a deep passion for community, the power of story, and assisting others in their personal growth and transformation journey. As a counselor, Amanda's experience includes trauma, EMDR, addiction recovery, and cognitive behavioral work with children, adolescents, and adults. She spent 5 years working alongside vulnerable and at-risk individuals and families helping them experience radical growth and obtain stability. Amanda has led addiction recovery groups and classes; child, teen, and adult support and psycho-educational groups; and has taught \ narrative therapy classes.

Regulation of Mental Health Professionals in Colorado

1. Redwood Counseling Services, LLC, ("RCS") is located at 7851 S Elati St, Littleton, CO 80120 and can be reached at (303) 351-5153. The Mental Health Professional located at RCS is Amanda Dwyer, LAC. Ms. Dwyer completed her Bachelor of Science Degree in Bible Studies from Clark Summit University in 2011.She went on to achieve her Master of Science in Counseling from Clark Summit University in 2018. Amanda Dwyer is a Licensed Addictions Counselor in the state of Colorado, License No. ACD.001808.

Counseling Specialties

Young adults	Adolescents	Trauma	Depression	Anxiety
Family Systems	Life transitions	Attachment issues		Narrative therapy

EMDR (Eye Movement Desensitization and Reprocessing)

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 a minor child/ren in their custody must sign this disclosure statement on behalf of their minor child under the age of twelve (12) years old.

In divorce or custody situations and because of the Colorado Department of Regulatory Agencies view on parental consent, it is RCS's policy to seek the consent of both parents/legal guardians, however this consent does not supersede any court order outlining parental decision-making and custodial rights. This policy is irrespective of any court determination, and this is the governing policy unless the child's health, safety, and welfare could be at risk. If this is the case, you must inform the RCS so that appropriate action for the protection and welfare of the child may be taken. This disclosure statement contains the policies and procedures of RCS 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 Addiction Counselor Examiners regulates Licensed Addictions Counselors and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through RCS'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 Unlicensed Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence take-home examination.

Certified Addiction Technicians must be a high school graduate, complete required training hours, pass the National Addiction Exam, Level I or equivalent, and complete 1,000 hours of supervised experience. Certified Addiction Specialists must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. Licensed Addiction Counselors must have a clinical master's degree, pass the Master Addiction Counselor Exam, and complete 3,000 supervised experience. Licensed Social Workers must hold a master's 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 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. An Unlicensed 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. Unlicensed 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. $115.00 per hour, $110.00 check or cash; $175.00 per 90 min EMDR Therapy Session

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 collections 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 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 not** a Medicaid provider. If you have or obtain Medicaid coverage that includes mental health services, I **am not** 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 $500.00 per hour. RCS requires an advance of $2000.00 (four hours) paid by cashiers check. Should services not meet or exceed the four-hour threshold, fees will be calculated according to time spent on services, an remaining fees returned within one week of all RCS's legal services ending.

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 RCS is not required to agree to a restriction request. Please review RCS 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 Addiction 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 an Unlicensed 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. §12-245-220. 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 RCS's Consent for Communication of Protected Health Information by Unsecure Transmissions.

"No Secrets" in Custody Circumstances Policy

7. When treating a Client who is a Minor under the age of twelve (12) and where there exists a custody arrangement between the parents or legal guardians (such as a divorce or separation), it is my policy to communicate with both parents/guardians via email (i.e. all communication will "cc" both parties). This policy is necessary to maintain transparency and professionalism, and to ensure the well-being of the therapeutic relationship with the Minor Client. This policy does not supersede any court order outlining decision-making or custodial rights but is or may be required by DORA. Further, I reserve the right, in my sole discretion, to engage in any individual email communication or face-to-face interaction in the lobby/waiting area. In the event that such an interaction occurs, I will notify the other party of said interaction and summarize the contents of the conversation, unless prohibited by professional rules or regulations regarding the protection of the health, safety, and welfare of the child/ren.

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:____Dr. Chris Miller_____
ADDRESS: _7851 S Elati St, Littleton, CO 80120__
TEL: ____(303) 351-5153__ext. 101_____
ROLE/CREDENTIALS: ___Clinical Director_____

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 Addictions Counselor Examiners, RCS 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. RCS cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records

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

Amanda Dwyer, LPC/LAC, 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. Ms. Dwyer uses a cloud-based service for storing or backing up information. The cloud-based backup system Ms. Dwyer uses is SimplePractice and the email service provider she uses is Microsoft Outlook. Ms. Dwyer 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 Ms. Dwyer 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 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 electronically stored information extends to these workforce members. If you have any questions about the security measures Ms. Dwyer employs, please ask.

Availability and Response Policy

11. My normal business hours are from Monday-Thursday, 9am-7pm. However, as a therapist, the majority of my business hours are devoted to seeing my clients in therapy, which means I am not always available for immediate contact via phone, text, or email. **This is especially true for emergencies, as I am not equipped to respond immediately.**

The best way to contact me is via phone. Every effort will be made to respond to you in a clear and timely manner. Voicemails and texts sent to (303) 351-5153 ext. 103 will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. Emails sent to Adwyer@redwoodcounselingservices.com will be returned within 48 hours, excluding Saturdays, Sundays, and holidays. Emails are reserved for scheduling needs, request for records, etc. All clinically-centered questions may be answered via phone or during a scheduled therapy session. It is my policy to return all phone calls, texts, and emails during my normal business hours (referenced above). I also reserve the right, in my sole discretion, to return communication outside of these hours; but any communication which I initiate outside of these normal business hours is in no way a guarantee or a promise of availability outside of my normal business hours.

Spiritual Counseling

12. As a Spiritual Counselor, I understand that faith and religion is an important component within counseling, and I strive to honor your faith and beliefs in the process. In addition to using psychological approaches and methodology, I may from time to time offer to incorporate passages of scripture, prayer, or other spiritual disciplines into my work. You retain the right to decline the integration of spiritualty and psychotherapy and this does not prohibit our ability to work together in a traditional psychotherapy capacity.

As a Client

You as a Client agree and understand the following:

1. I understand that RCS 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 RCS'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 RCS'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 RCS does provide Teletherapy, such as therapy over telephone or video platform. If both therapist and client agree to engage in Teletherapy as a treatment modality, I may be asked to complete an additional consent form, and that I agree to utilize a secure and HIPAA compliant means for communication to ensure confidentiality and the protection of private information.

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 RCS 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" RCS'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 RCS's page 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 my 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 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. I may also contact the National Suicide Prevention Lifeline at 988. Amanda Dwyer, LAC, 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 her level of competence or outside of her scope of practice, my therapist is legally required to refer, terminate, or consult.
9. 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.

10. 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.

11. I understand that should I choose to discontinue therapy for more than sixty (60) days by not communicating with RCS 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 RCS. Ability to resume therapy after sixty (60) days will depend upon my therapist's availability and will be within her 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.

12. 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.

13. 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 her relatives, friends, the relatives of friends, people known socially, or business contacts.

14. I understand that should I cancel within 48 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.

15. I also affirm, by signing this form, I am at least twelve (12) years old and consent to treatment and therapy services here at RCS. In the event 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) and for whom I am requesting therapy services here at RCS, I understand it is RCS's policy to seek the consent of both parents/legal guardians. Further, in the event of a custody or divorce dispute, I and the therapist must obtain the consent from the other parent/legal guardian for my minor child/ren's treatment in accordance with DORA policy.

If I am the non-custodial parent signing this consent form for my minor child/ren's treatment in accordance with DORA's policy, I understand that my access to my child/ren's treatment and client record may be limited by court order.

16. 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 RCS, 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. I also understand that it is RCS's policy to request and seek consent from both my minor child/ren's parents, but that such consent does not supersede the Court Order Custody Agreement and/or Parenting Plan. By signing this form, I understand and consent to RCS's "No Secrets" in Custody Circumstances Policy as outlined above. 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.

17. By signing this form, I affirm that I am fully informed of the therapy services I am requesting, and that RCS 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

_____ _____

Amanda Dwyer, LPC/LAC, Signature Date

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CLIENT INFORMATION (For All Clients)				
Client Name (First, Middle Initial, Last)		❒ Single ❒ Married	❒ Male ❒ Female	Birth Date
Street Address		City, State, Zip		
Home Phone	Work Phone	Cell Phone	Email	
Occupation	Employer or School		Primary Care Physician	
Who referred you to this practice	Have you seen our website? ❒ Yes ❒ No		General Health Status	
Any previous counseling? With whom?				
List all medications				

Emergency Contact	Relationship to Client	
Home Phone	Work Phone	Cell Phone
Responsible for Payment	Home Phone	Cell Phone
Street Address	City, State, Zip	

IF MARRIED		
Spouse's Name (First, Middle Initial, Last)	Birth Date	Cell Phone
Occupation	Employer or School	Work Phone

IF A MINOR		
Mother's Name	Occupation	Employer
Street Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Father's Name	Occupation	Employer
Street Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Siblings (first and last names and ages)		

The above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature

** Payment due at time of service**

Truth • Hope • Transformation

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7851 S Elati St, Littleton, CO 80120
P: (303) 351-5153 ext. 103 E: Adwyer@redwoodcounselingservices.com

NOTICE OF PRIVACY POLICIES AND PRACTICES

This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

RCS believes it may be a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and thus provides its clients with this Notice of Privacy Policies & Practices and complies with the procedures and protocols listed herein. If RCS is determined not to be a covered entity under HIPAA, it will still follow this Notice of Privacy Policies & Practices regarding use and disclosure of PHI; however, the client may not be entitled to the rights set forth in the "Your Rights as a Client" section.

Given the nature of RCS work, it is imperative that it maintains the confidence of client information that it receives in the course of its work. RCS is a mental health practice that provides mental health services. RCS practice works solely to provide the best counseling treatment options to its clients. RCS is prohibited from releasing any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the practice are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is my policy to:

1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. provide every client who receives services with a copy of this Notice of Privacy Policies;
3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. ensure the confidentiality of all client records transmitted by facsimile;
5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

RCS is required to follow all state and federal statutes and regulations including Federal Regulation 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, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that I create or receive, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes any such information described above that I transmit or maintain in any form this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

Your Rights as a Client

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record.

- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee to fulfill your request.
- If we deny your request, in whole or in part, we will let you know why in writing and whether you have the option of having the decision reviewed by an independent third party.

Ask us to correct your mental health record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Please review the Consent for Communication Of Protected Health Information By Non-Secure Transmissions.
- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communications, we will not communicate with you via electronic means.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Additional restrictions.

- You have the right to request additional restrictions on the use or disclosure of your mental health information. However, we do not have to agree to that request, and there are certain limits to any restriction. Ask us if you would like to make a request for any restriction(s).

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.us. Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

Uses and Disclosures of Protected Health Information

A use of PHI occurs *within* a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when RCS reveal PHI to an outside party (i.e., RCS provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

RCS may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during your therapist's absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. Payment: disclosing and using your PHI so that RCS can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
3. Health Care Operations: disclosing and using your PHI to support RCS business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that RCS may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes RCS would not need to disclose a client's entire

medical record in order to receive reimbursement. RCS would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

RCS is required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is RCS policy that a client must complete an Authorization for Release of Protected Health Information it provides prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, RCS is prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment without written authorization, unless one of the following exceptions arises:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against RCS, etc. This does not include a request by you or another party for your records).
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at RCS office or against any person who works for RCS; A minor or elderly client reports having been abused or there is reasonable suspicion that abuse has or will take place; Client is planning to harm another person, including but not limited to the harm of a child or at-risk elder; Client is imminently dangerous to self or others).
4. Address workers' compensation, law enforcement, and other government requests.
5. Respond to organ and tissue donation requests.
6. Business Associates: RCS may enter into contracts with business associates to provide billing, legal, auditing, and practice management services that are outside entities. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
7. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Before using or disclosing PHI for one of the above exceptions, RCS staff must consult its Privacy Officer (Dr. Chris Miller) to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that RCS will never market or sell your personal information without your permission.

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CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION VIA UNSECURE TRANSMISSIONS

This consent form is for the communication of Protected Health Information ("PHI") that Redwood Counseling Services ("RCS") may transmit without the written authorization of the client as described in the Uses and Disclosure section of RCS's Notice of Privacy Policies.

I, _____, hereby consent and authorize RCS to communicate my PHI through the following unsecure transmissions (please initial all your choices):

_____ Cellular/Mobile Phone (this includes text messaging & voicemails).
Please Insert Cell Phone Number: _____
_____ Unsecured Email.
Client's Email: _____ □ Send □ Receive
Please Circle One: Work Personal
Therapist's Email: _____ □ Send □ Receive
_____ I do not wish to have my protected health information transmitted electronically.

Should we agree to communicate by the approved communications listed above, i.e., text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, cannot guarantee that those communications will remain confidential. Even though RCS may utilize state of the art encryption methods, firewalls, and/or back-up systems to help secure our communication, there is a risk that the electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third-party. There is never a 100% guarantee information will remain confidential when transmitted electronically.

I, _____, consent to RCS transmitting the following PHI by the above selected electronic communications (please initial all your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing and payments
_____ Information related to your mental health treatment (i.e., personal materials, forms, suggested articles, homework, etc.)
_____ Information related to RCS's operations
_____ Other information; Please describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

_____ _____
Signature of Client/Parent/Legal Guardian Date

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Special Authorizations

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: RCS may keep and maintain "Psychotherapy Notes", which may include but are not limited to notes RCS makes about your conversation during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." RCS will obtain a special authorization before releasing your Psychotherapy Notes.

HIV Information: Special legal protections apply to HIV/AIDS related information. RCS will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. RCS will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) RCS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, RCS is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving test results unattended where third parties without a need to know can view them.
2. Any PHI received as an employee, intern, or volunteer about a client or potential client, may not be used or disclosed for non-work purposes or with unauthorized individuals. RCS may only use and disclose such PHI as described above.
3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
4. Seeking legal counsel in uncertain situations and/or incidences.
5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information. Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services.
6. Implementing FAX security measures
7. Obtaining your consent prior to sending any PHI by unsecure electronic transmissions
8. Providing information on my electronic record-keeping.

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Your Choices

For certain health information, you can tell RCS (verbal authorization) your choices about what it shares. If you have a clear preference for how RCS shares your information in the situations described below, talk to RCS. Tell RCS what you want it to do, and it will follow your instructions. RCS may request you sign a separate document if you authorize it to share certain PHI. You may revoke that authorization at any time for future disclosure.

In these cases, you have both the right and choice to tell RCS to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell RCS your preference, for example if you are unconscious, RCS may go ahead and share your information if RCS believes it is in your best interest and for your care/treatment. RCS may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Changes to the Terms of this Notice
RCS can change the terms of this notice, and the changes will apply to all information RCS has about you. The new notice will be available upon request, in RCS' office, and on its web site.

This notice is effective _____, 2023.

_____ _____
Client Signature Date

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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CREDIT CARD AUTHORIZATION FORM

Redwood Counseling Services ("RCS"), requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged $_____ after each session on the day the session occurs. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-shows fees.

□ I do not authorize RCS to charge my credit card after each session but only for additional fees I and/or my minor child/ren incur as set forth in RCS 's disclosure statement and policies. I will be notified of the type of additional fees I and/or my minor child/ren incur.

□ I authorize RCS to charge my credit card $_____ after each session and for any and all additional fees I and/or my minor child/ren incur.

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for sixty (60) days, your account may be sent to collections. RCS reserves the right to send your account to collections, in accordance with RCS' policies and procedures; at any time after your account is considered past due.

By signing this authorization form, you agree to notify RCS of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

Redwood Counseling Services accepts only the following credit cards:
□ Visa
□ Discover
□ American Express
□ Mastercard

Name on Credit Card:_____

Type of Credit Card: Visa __ MasterCard __ Discover ___ American Express ___

Credit Card Number_____

CCV Code: _____ Expiration Date :_____

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Card Holder's Full Address, including zip code (the mailing address for your Credit Card statements):

_____

_____

This credit card authorization form will remain in effect and on file at RCS unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination. RCS will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

Please check one:

□ Card Holder is the client (or parent/legal guardian) receiving services from RCS.
I hereby authorize RCS to charge the above credit card number for payment of the counseling fees I or my minor child/ren incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above.

_____ _____
Client/Parent/Legal Guardian Signature Date

□ Card Holder is a third-party payer for the client receiving services from RCS.
I_____, hereby authorize RCS to charge the above credit card number for payment of the counseling fees (Client)_____ incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I understand as a third-party payer that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about Client beyond payment.

_____ _____
Third-Party Payer's Signature Date

I, _____, authorize RCS to communicate with the above Third-Party Payer solely as it may relate to payment for services I receive from RCS.

_____ _____
Client's Signature Date

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Teletherapy Informed Consent Form

This Informed Consent for Electronic Psychotherapy contains important information concerning engaging in electronic psychotherapy or Teletherapy. Please read this carefully and let your therapist know if you have any questions. **This consent shall only apply to clients and therapists physically within the State of Colorado seeking therapeutic treatment within the State of Colorado.** This Informed Consent shall be signed in conjunction with Redwood Counseling Services ("RCS") Disclosure Statement.

Teletherapy allows individuals who may not have local access to a mental health professional and/or specialized treatment to receive services via electronic means (e.g., telephone, email, HIPAA compliant face-to-face service via the Internet). Teletherapy may also be used when issues related to scheduling, transportation, child-care and/or mobility arise during the course of treatment.

This Informed Consent is between:

Client: _____ and Amanda Dwyer.

Diagnosis and/or Treatment Plan: _____

_____

Reason(s) Teletherapy is Appropriate for this Client:

_____

_____

Benefits and Risks of Electronic Psychotherapy

Electronic psychotherapy, also known as Teletherapy, is different from traditional therapy in that the client and therapist do not meet face-to-face in-person. One of the benefits of electronic psychotherapy is that the client and therapist can continue therapeutic sessions without being in the same place. This can be convenient if either the client or therapist is out of town or the client or therapist is unable to attend a scheduled session in person.

Although there are benefits of electronic therapy, there are also significant risks involved. These risks include, but are not limited to: losing the ability to read physical cues, vocal cues/tones, and facial expressions; an inability to provide immediate emergency services/care; experiencing technical issues that disrupt the counseling session; a risk that the communications may be overheard if the client or therapist does not conduct the session in a secure/confidential place; and there is a risk that the communications may be accessed by unknown third-parties regardless of the security measures in place.

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Method of Electronic Psychotherapy

Based upon the Client's needs and the therapist's assessment of those needs, the following method of electronic psychotherapy has been chosen:

☐ Telephone ☐ Video (doxy.me) ☐ Other:_____

This method of electronic psychotherapy was chosen because: _____

_____

Security Measures

RCS uses the following security measures to ensure that the communications are secure:

- State-of-the-art, HIPAA- and HITECH-compliant encryption through Doxy.me
- Encrypted, password-protected computers & devices.
- Sessions conducted in a private location where others cannot hear me.

Confidentiality

Confidentiality still extends to any communications done through electronic psychotherapy. 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 gain access to 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 communications may be compromised, unsecured, and/or accessed by a third-party.

In order to maintain confidentiality when engaging in electronic psychotherapy, it is important that all sessions be conducted in a confidential place. This means that you as the client agree to participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation. I cannot guarantee that the place you choose to conduct the session is confidential. Do not have sessions in public places such as internet cafes or libraries.

The extent of confidentiality and the exceptions to confidentiality that I listed in my Disclosure Statement still apply in electronic psychotherapy. In general information disclosed to a mental health professional in the course of a professional psychotherapeutic relationship cannot be disclosed without the client's consent. Exceptions to this general rule include:

- The disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S. §13-90-107
- I am required to report child abuse or neglect situations
- I am required to report the abuse or exploitation of an at-risk 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, and may be required to take immediate action to protect you or others from harm
- 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

There may be additional exceptions to confidential communications that I will identify to you as the situations arise throughout our professional relationship.

In-Person Sessions

From time to time, we will schedule in-person sessions to "check-in" with one another. If at any time while we are engaging in electronic psychotherapy, I determine, in my sole discretion, that electronic psychotherapy is no longer effective we will discuss options of returning to face-to-face in-person counseling.

Emergencies and Technology

Unlike in traditional in-person psychotherapy where a therapist may be better able to evaluate the seriousness of a client's threats to harm oneself or others based on a combination of physical, behavioral and verbal cues; assessing and evaluating threats and other emergencies is more difficult when conducting psychotherapy electronically.

As such, I will ask you where you are located at the beginning of each session so that if I am required to contact emergency personnel (police, hospital, fire), I can alert them of your location. We will not proceed with the session until emergency telephone numbers are located. This emergency plan is not to "track" you or keep "tabs" on you, but rather to ensure your safety.

If the session cuts out, meaning the technological connection fails, and you are having an emergency **do not call me back**, but call 911, the Colorado Crisis Hotline at 844-493-TALK (8255), or go to your nearest emergency room. *Call me after you have called or obtained emergency services.*

If the session cuts out and you are not having an emergency, hang up and I will wait two (2) minutes and then re-contact you via the electronic psychotherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes then call me on the phone number listed above.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

You may be required to have certain system requirements to access electronic psychotherapy via the method set forth above. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy. The specific requirements for the method chosen above are:

_____

_____

_____

In order to maintain confidentiality and security for your electronic devices, please review the security protocols for

- https://help.doxy.me/en/articles/95911-security-and-privacy-overview

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Fees

The same fee rates shall apply for electronic psychotherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted using electronic psychotherapy. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session.

Sexual Intimacy:

In a professional relationship (such as psychotherapy), sexual intimacy between a therapist 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 Unlicensed Psychotherapists.

Records

The electronic psychotherapy sessions shall not be recorded in any way unless agreed to by mutual consent. However, there may be an electronic record stored on (Doxy.me). I will maintain a record of our session in the same way I maintain our in-person sessions in accordance with my electronic record storage police set forth in my Disclosure Statement.

Informed Consent

I, _____, the client, having been fully informed of the risks and benefits of electronic psychotherapy; the security measures in place, which include procedures for emergency situations; the fees associated with electronic psychotherapy; the technological requirements needed to engage in electronic psychotherapy; and all other information provided in this informed consent, agree to abide by and understand the procedures and policies set forth in this consent; and, voluntarily and not under duress or coercion consent to engaging in electronic psychotherapy with Dr. Chris Miller.

I understand that I may revoke this agreement at any time for any reason. Such revocation is not retroactive.

_____ _____

Signature of Client Date

_____ _____

Amanda Dwyer, LPC/LAC, Signature Date

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EMDR INFORMED CONSENT FORM

Eye movement desensitization and reprocessing (EMDR) therapy is an extensively researched, effective psychotherapy method proven to help people recover from trauma and other distressing life experiences including PTSD, anxiety, depression and panic disorders. It can also be highly effective in supporting the treatment of complex trauma, addiction, attachment issues, eating disorder, phobias, and obsessive compulsions.

EMDR is recognized as an effective treatment by organizations such as the America Psychiatric Association, the International Society for Traumatic Stress Studies, the Substance Abuse and Mental Health Services Administration, the U.S. Department of Veterans Affairs and Department of Defense, the Cochrane Database of Systematic Reviews, and the World Health Organization, among others.

EMDR therapy is designed to resolve unprocessed distressing memories in the brain. For many clients, EMDR therapy can be completed in fewer sessions than other psychotherapies.

EMDR therapy does not require talking in detail about the distressing issue or completing homework between sessions. EMDR therapy, rather than focusing on changing the emotions, thoughts, or behaviors resulting from the distressing issue, allows the brain to resume its natural healing process. EMDR utilizes dual stimulation to support the bilateral activation of both hemispheres of the brain. This assists the treatment process by making the neurological reprocessing more holistically engaged and integrated.

Our brains have a natural way to recover from traumatic memories and events. This process involves communication between the amygdala (the alarm signal for stressful events), the hippocampus (which assists with learning, including memories about safety and danger), and the prefrontal cortex (which analyzes and controls behavior and emotion). While many times traumatic experiences can be managed and resolved spontaneously, they may not be processed without help.

Stress responses are part of our natural fight, flight, or freeze instincts. When distress from a disturbing event remains, the upsetting images, thoughts, and emotions may create feelings of overwhelm, of being back in that moment, or of being "frozen in time." EMDR therapy helps the brain process these memories and allows normal healing to resume. The experience is still remembered, but the fight, flight, or freeze response from the original event is desensitized.

EMDR therapy is a mental health intervention and should only be offered by properly trained and licensed mental health clinicians.

For more information or to view the research, please visit EMDRIA.org.

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In order to proceed with EMDR therapy, the client must:

- Disclose to the therapist if the client has a history of or currently struggles with eye problems, a diagnosed heart disease, elevated blood pressure, or is at risk of stroke, heart attack, seizure, or other medical condition that may put the client at risk. Women who are pregnant should consult with their obstetrician due to the stress related to reprocessing distressing events before participating in EMDR therapy.
- Disclose to the therapist any medications that they are currently using. Some medications, such as benzodiazepines, may reduce the effectiveness of EMDR therapy.
- Discuss with the therapist any symptoms of dissociation, unexplained somatic symptoms, sleep problems, flashbacks, depersonalization or memory lapses.
- Inform the therapist if the client is wearing contact lenses and agrees to remove them if they impede eye movement.
- Be able to use emotional regulation techniques in and out of session and with or without assistance from therapist or another person.
- Discuss with the therapist all aspects of an upcoming legal court case where testimony may be required. Treatment may need to be postponed if the client is a victim or witness to a crime that is being prosecuted. Memories that are reprocessed using EMDR may face, blur or disappear which can lead to testimony being challenged in court.
- Be available and committed to consistent session attendance and participation. While the effectiveness of EMDR therapy treatment is known to be rapid, feelings of significant distress may arise mid-process between sessions. Therefore, it is important that the client understands and agrees to follow through on the commitment to the EMDR process.

I have read and I understand the possible outcomes of EMDR therapy listed above and understand that I can end EMDR therapy at any time for myself or my participating child. I understand that there may be risks involved in ending treatment early. I hereby give consent to participate in EMDR treatment and I assume any risks involved in such participation.

Name of Client (Printed):_____

_____

Signature of Client/Parent/Guardian Date

_____

Signature of Amanda Dwyer, LPC/LAC Date