KELLEY GRAY, M.A.
LICENSED PROFESSIONAL COUNSELOR

Disclosure Statement

The State of Colorado requires that psychotherapy clinicians provide clients with certain information about the psychotherapy process. Please take time to read this page carefully, ask about any matters that seem unclear and sign at the bottom of this statement. Signing this form indicates you agree to and understand the policies of Kelley Gray M.A., L.P.C., LLC. Please retain a copy for your own personal records.

As a Licensed Professional Counselor, I strive to integrate sound psychological, medical and spiritual principles into your treatment. You are entitled by law to receive information about my education, credentials, methods of therapy, techniques utilized, estimation of the duration of your therapy, fee structure, risks and benefits of therapy, confidentiality, and access to records. You also have the right to know what other treatment options are available and the possible effectiveness of those alternatives. You may at any time seek a second opinion from another clinician and/or terminate therapy.

Education, Credentials & Affiliations

B.A. in Psychology • Mississippi State University
M.A. in Community Counseling • Denver Seminary
Licensed Professional • Counselor State of Colorado (LPC #3929)
Nationally Certified Counselor (NCC)
Member of the American Counseling Association

The Colorado State Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the profession of psychotherapy. Any questions, concerns or complaints regarding the practice of psychotherapy may be directed to the State Board. Sexual intimacy between client and therapist is illegal and should be reported to the Board:
Mental Health Occupations Grievance Board • 1560 Broadway, Suite 1340 • Denver, CO 80203 • 303.894.7766

CONFIDENTIALITY

Generally speaking, information provided to and by the client during therapy sessions is ethically confidential. The therapist cannot be forced to disclose information without the client's consent except under the following conditions (Colorado Statute 12-43-218, C.R.S. 1998): legal confidentiality does not apply in a criminal or delinquency proceeding, client-initiated court cases or grievance inquiries, providing information to insurance companies, supervision or consultation, grave disability, court order, or client's authorization to release information.

It is the right of parents of a minor to be informed about their child's therapy. A minor is defined as a child under the age of 18.

4901 East Dry Creek Road, Suite 150 • Centennial, CO • 80122
303.669.2769 • kelley@kelleygray.com

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Mental health providers are required by law to report cases of any child neglect, physical abuse, or sexual abuse to County Child Protective Services. Additionally, if any individual becomes dangerous to himself/herself or others, or is incapable of caring for himself/herself, confidentiality must be broken in order to arrange for appropriate care.

OFFICE POLICIES & FEES

Fees are due at time of services
$130 per 50 minute session for individuals
$135 per 50 minute session for couples
Phone calls or email exchanges over 15 minutes will be pro-rated according to hourly fee
Please let me know as quickly as possible if you are unable to keep your appointment
I require 48 hours notice to change or cancel and appointment, except in the case of an emergency or illness. Please call as soon as possible if you know you will have to miss an appointment for any reason.

MESSAGES & COMMUNICATIONS

Feel free to call, text or email me. While I obviously cannot offer 24 hour care I do welcome you to contact me via the following avenues and sometimes ask you to do so as part of the course of your therapy. I will do my best to return your call/email/text within 24 hours or the next business day. Additional fees may apply if communications are lengthy or unscheduled.

Business Cell: 303.669.2769
Email: kelley@kelleygray.com

By signing below, you acknowledge you have read and I have read aloud to you the preceding information, understand your rights as a client and agree to counseling under these conditions.

Printed Name

_____

Client Signature

_____ Date_____

Therapist Signature

_____ Date_____

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