Disclosure Statement

Sharon Kocina, M.A., L.P.C.
303-444-2003

I have a Master's degree in Counseling Psychology with an emphasis in Marriage and Family Therapy from the University of Colorado, Denver—earned May, 1995. My undergraduate degree is a Bachelor of Science in Finance and Accounting from the University of Colorado, Boulder—earned May, 1984. I am a Licensed Professional Counselor (license # 1885).

The practice of psychotherapy is regulated by the State Board of Licensed Professional Counselor Examiners. The address and telephone number of the grievance board is 1560 Broadway, Ste. 1340; Denver, CO 80202; the telephone number is 303-894-7800.

You are entitled to receive information about the methods of therapy I use, the duration of therapy (if known), and my fee structure. Please ask if you would like this information.

You can seek a second opinion from another therapist or may terminate therapy at any time (except under special circumstances).

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

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality which include: (1) suspected abuse or neglect of a child, (2) suspected abuse or neglect of an at-risk adult, (3) suspected abuse or neglect of an elder that is 70 years of age or older, (4) if you are at risk of hurting or killing yourself or someone else – I am required to initiate a mental health evaluation and possible hospitalization, (5) if I am court-ordered to testify or produce my records, (6) if something you tell me is a risk to national security. Numbers 1 – 3, 5 and 6 must be reported to the appropriate authorities.

When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officers information concerning my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, should it become necessary.

Under Colorado law, C.R.S. 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA Standards.

I agree not to record our sessions without your written consent; and you agree not to record a session or a conversation with me without my written consent.

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena me to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney making recommendations concerning custody. The court can appoint professionals who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibililities or parenting time in the best interest of the family's children.

In cases where I meet the client outside of my office, someone in my professional group will be informed of the location, with whom and timing of session.

If we are doing distance therapy, it is my understanding that we will be conducting therapy via Zoom. I further understand, acknowledge and agree that this therapy is taking place in the State of Colorado and, therefore, governed by the laws of Colorado. Hence, our therapy will be treated, for all purposes, as having taken place in the State of Colorado.

I have a professional will in the case of my death or incapacitation. By signing this document, the client agrees to waive confidentiality, in the case of my death or incapacitation so that the executor may access my confidential files and information in order to take necessary action.

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

I have read the preceding information, and I understand my rights as a client or as the client's responsible party. I also acknowledge that I have received a copy of this Disclosure Statement.

_____ _____

Client Signature Date Client Signature Date

_____ _____

Client Signature Date Client Signature Date

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Therapist Signature Date