

**Ivette Lopez Bledsoe, LCSW, BCIA-C**  
Mind / Body Therapist and Biofeedback Therapist  
503 Remington Street, Suite 003 / Fort Collins, CO 80524 / Phone: 970-530-0135

### **Information Regarding Delivery of Services**

This information outlines policies concerning my practice and clarifies your rights as a client. I apologize if this information seems a little impersonal, but I am required by law to give you this information prior to us beginning our work together. Please feel free to discuss this information with me at any time.

**My Background and How I Practice:** I received my Master of Social Work degree in 1993 from the University of North Carolina at Chapel Hill. In June 2006, I obtained my license as a clinical social worker in Colorado. Since 1993, I have worked as a clinical social worker in a variety of medical settings. I am certified as a Biofeedback Therapist by the Biofeedback Certification Institute of America, EMDR Level II trained, a Certified Health Education Specialist, and a Certified Yoga instructor. I obtain on-going consultation by a licensed therapist.

My task as a therapist is to help you bring about the changes you hope to make. I focus on mind / body interactions in order to promote self-knowledge and self-regulation. I utilize cognitive-behavioral strategies and interpersonal psychotherapy. I place a strong emphasis on teaching new skills and enhancing your personal resources to overcome a presenting problem. To facilitate change, I adopt different roles: teacher, consultant, counselor and coach. I provide readings, writing and / or process assignments, and logs for maintaining behaviors. I see our relationship as a collaborative process and expect you to do your best in completing assignments, and I expect you to bring forth barriers you may be having in initiating change.

**Session Time and Fees:** The cost of the initial session ranges from \$90.00 - \$105.00 and lasts anywhere from 75-90 minutes. The cost of the follow-up sessions ranges from \$55.00 - \$90.00 and lasts anywhere from 30 to 90 minutes. The cost is dependent upon the time spent. Sessions are typically scheduled weekly. We will agree on the appropriate follow-up time and cost in advance and makes adjustments along the way.

**Personal Safety:** In a professional relationship (such as ours) sexual intimacy between a client and therapist is never appropriate. Should sexual intimacy occur it should be reported to the Department of Regulatory Agencies at: 1) Phone: 303-894-7766; 2) Address: 1560 Broadway, Suite 1350, Denver, CO 80202.

**Insurance and method of payment:** If your medical insurance has outpatient mental health benefits, you may be eligible for some coverage of the therapy costs. However, it is highly unlikely that any insurance plan will cover 100% of the costs. Additionally, many companies contract with managed care companies to oversee mental health benefits and often only work with a limited panel of providers. If I am not part of the provider network, my services will not be fully covered. It is your responsibility to verify your coverage as you are ultimately responsible for the bill. You have a choice of three methods of payment: VISA/Mastercard, check or cash. You may pay me at the end of each session or my bookkeeping office can send you a bill.

**Emergencies:** Because I practice independent of a larger outpatient clinic, I am unable to assume responsibility for emergencies or states of urgency. I encourage you to develop some additional support system or to have access to other individuals and /or agencies in case of emergencies. I do not carry a pager and therefore you can not depend on reaching me immediately. Below is a list of emergency agency numbers.

Local Emergency number: 911 or 495-8090  
Larimer County Mental Health Center Emergency Line: 221-2114  
Mountain Crest Hospital: 207-4800  
First Call (Crisis Hotline): 407-7066 (8:00 am – 5:00 pm daily)

**Cancellations:** Out of courtesy for others in need of an appointment and my time, I request that you give a 24 hours notice if you need to cancel an appointment. Otherwise, except in case of personal emergency, sudden onset of illness or inclement weather, you may be charged for the reserved time.

**Messages:** You may use my voice mail for messages any time (970-530-0135). I check for messages throughout the day during normal business hours (9:00 am – 5:00 pm) Monday through Friday.

### **Information Regarding Notice of Privacy Practices**

Professional ethics, Colorado State Law and HIPAA all require that your privacy be carefully protected. This means that I may not communicate to anyone else anything you talk about with me. There are a few exceptions to this rule and they are listed below.

#### **Legal and Payment:**

- 1) You may sign a release of information form that allows me to disclose information to individuals or institutions specified by you.
- 2) If you feel that you are in danger of causing immediate harm to yourself or another person, I am required by law to report this to the appropriate authorities.
- 3) If I am ordered by a court of law to disclose information about you (e.g., if I am served with a legitimate subpoena), I am required in some cases to respond to that order.
- 4) If you reveal information concerning physical or sexual abuse of a child, I am required by law to report this knowledge to the appropriate authorities.
- 5) If you are in therapy by a court of law.
- 6) If you are involved in a criminal or delinquency proceeding.
- 7) I may need to report problems with medications or medical products to the manufacturer and to the FDA, or may notify patients of recalls of products they are using.
- 8) If you are a member of the armed forces, I may release information about you as required by military command authorities or the Department of Veterans Affairs. I may also disclose medical information to federal officials for intelligence and national security purposes, for Presidential Protective Services, or to the Department of State for its security issues.
- 9) I may have to use or disclose information about you to get paid for services and supplies I provide to you. For example, your health plan or health insurance company may request to see parts of your medical record before they will pay me for services rendered.

#### **Your Rights:**

- 1) **Right to request information about you:** You have a right to look at the information about you and to get a copy of that information. To request information, submit a written request. You may be charged for the costs to copy the information. You will be informed in advanced what the cost of copying the information will cost. You can look at your record at no cost. The law requires that I keep the original record.
- 2) **Right to request to amend or supplement information about you that you believe to be incorrect or incomplete:** If you see information about you that you believe to be incorrect or incomplete you have a right request that it is amended. Please submit your amendment in writing.
- 3) **Right to get a list of certain disclosures of information about you:** You have the right to request a list of certain disclosures I made of information about you.
- 4) **Right to request confidential communications:** You have the right to request that I communicate with you in a way that you feel is more confidential.
- 5) **Right to request restrictions on how I will disclose information about you for treatment or payment.** I am not required to agree to your request, but if I do agree, I will comply with that agreement unless information is needed for emergency purposes.

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**Authorization for Therapy**

I, knowing that I have a condition requiring treatment, voluntarily agree to work with Ivette Lopez Bledsoe, a licensed therapist, certified biofeedback therapist and EMDR Level I trained. I have received general information about the practitioner and the service I am seeking. I am aware that I am entitled to receive additional information about methods of treatment interventions used, duration of therapy (if known) and fee structure. I can also receive specific information about the practitioner’s degrees, credentials and licenses, if requested by me. I understand that I might experience temporary physical and emotional discomfort as a result of the therapy. I agree to report any physical and emotional discomfort to Ms. Bledsoe or my doctor. I understand that there are no guarantees concerning the care that I am seeking and that I am free to obtain a second opinion from another therapist or stop treatment at any time.

**I have read and have been given a copy of Ms. Bledsoe’s “Information Regarding Delivery of Services” and “ Information Regarding Notice of Privacy Practice” or it has been read to me.**

\_\_\_\_\_  
**Client Signature (or Guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**If Guardian is signing please state relationship to minor**

\_\_\_\_\_  
**Ivette Lopez Bledsoe**

\_\_\_\_\_  
**Date**