

Disclosure Statement

Sarah E. Burgamy, Psy.D.
Licensed Psychologist
1756 High Street
Denver, CO 80218
303-807-3300

Education/Degrees

Psy.D., University of Denver, Denver, Colorado: Doctor of Psychology, 2006
M.A., University of Denver, Denver, Colorado: Master of Clinical Psychology, 2004
B.A., Dartmouth College, Hanover, New Hampshire: Bachelor of Arts, 2000

Regulation of Psychotherapists

The Colorado State Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. Concerns or complaints regarding the practice of psychotherapy may be directed to the Department of Regulatory Agencies: State Board of Psychologist Examiners, 1560 Broadway, Suite 880 Denver, CO 80202 (303) 894-7766.

Client Rights and Important Information

- You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration (if known) of your therapy, and my fee structure for services.
- You can seek a second opinion from another therapist or terminate therapy at any time.
- In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies.
- Generally speaking, information provided by and to a client in a professional relationship with a psychotherapist is legally confidential, and the therapist cannot disclose the information without the client's consent. There are several exceptions to confidentiality which include: (1) I am required to report any suspected incident of child abuse or neglect to law enforcement; (2) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (3) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled, as a result of a mental disorder; and (4) I am required to report any suspected threat to national security to federal officials.

I have read the preceding information and understand my rights as a client. I also acknowledge I have received a copy of this Disclosure Statement.

Client Signature

Date

Therapist/Witness

Date

Consent for Treatment and Financial Agreement

I voluntarily consent to participate in mental health and/or consultation services with Sarah E. Burgamy, Psy.D. Dr. Burgamy is registered with the state of Colorado as a Licensed Psychologist, license # 3187.

- Rate for Individual, Child/Adolescent, Family, Couple's Treatment, Consultation by Phone or In Office is: \$120.00 (45-50 Minute Hour)
- Telephone calls under 15 minutes are free of charge. Any call 15 minutes or more will be charged a base rate of \$35.00 per 15 minutes and \$10.00 for each additional 5 minute period.

***If you are currently receiving a rate reduction, which has been previously arranged with Dr. Burgamy, please enter this hourly (45-50 Minute Hour) rate here: _____.**

- Therapy Partner Corporation is an outsourced billing agency utilized by Dr. Burgamy. Therapy Partner Corporation will manage all administrative and billing functions associated with the practice. This will allow the practice to continue to focus on service oriented tasks aimed at ensuring quality care. Payment for your treatment will be electronically deducted from a debit/credit card account at the time of service, unless check or cash payment is preferred. Visa, Master Card, and Discover cards will be accepted. Please see Electronic Payment Authorization Form.
- I understand that I am responsible for payment at the time services are rendered. I agree to give ***at least 24 business hours notice*** in the event I need to cancel or change an appointment. **For appointments on Mondays, notice of cancellation will be made by the preceding Friday.** If I fail to give such notice, I understand that I will be charged a full session fee as a late cancellation fee. Further, I understand that if I fail to call and do not show up for an appointment I will also be charged the full fee for that missed session.
- I understand that my insurance company will not be billed for therapy, or for cancelled or missed appointments. If I wish to submit a bill to my insurance provider, I understand that I am responsible for such a submission.
- If a report, letter or consultation by an outside party is requested, I understand that I will be billed the usual hourly rate for the time needed to prepare the document, or to conduct an in person consultation. Telephone consultations will be billed at the aforementioned rate in this instance as well.
- Any bill not paid within thirty days will be assessed a service charge at the rate of 1.5% per month. In the event that billing efforts fail, delinquent accounts will be subject to Collections Recovery at the discretion of Sarah E. Burgamy, Psy.D. Additionally, an attempt will be made by Dr. Burgamy to develop a payment plan with clientele who wish to seek this option for outstanding balances. By signing this agreement you are agreeing to this procedure.

I have read and understand the Consent for Treatment and Financial Agreement.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____
(Parent or Guardian if client is a minor)