Fara Murata LCSW
RAPHA COUNSELING CENTER
Office: 720-898-4800 Fax: 720-898-5169
www.raphacc.com

PROFESSIONAL DISCLOSURE

I am pleased that you have selected me as your therapist. This is designed to inform you about my background and to ensure that you understand our professional relationship. My name is Fara Murata, please allow me to introduce myself.

I am a Licensed Clinical Social Worker (LCSW) and have earned a Master's Degree in Social Work (MSW) from the University of Denver with an emphasis in Child Welfare, and a Bachelor of Arts Degree (BA) in Psychology with a Minor in Sociology from the University of Colorado. I am an nutritional specialist and am currently studying for a Certificate in Nutritional Endocrinology at the Institute of Nutritional Endocrinology. I've had experience with anxiety, depression victims of trauma, life changes, parent-child conflict, victims of sexual abuse and individuals struggling to get through life due to illness or undiagnosed health issues.

My professional experience has included therapy with individuals and families. My special interest is treating the whole person to find lasting change. I am certified in EMDR therapy (Eye Movement, Desensitization, and Reprocessing). You may find my credentials at www.raphacc.com.

I am a member of the National Association of Social Workers and the National Association of Christian Social Workers, American Professional Society on the Abuse of Children and EMDRIA.

CLIENT RIGHTS

I accept only clients in my practice that I believe have the capacity to resolve their problems with my assistance. We will set treatment goals together and re-evaluate them throughout treatment. Some clients need only a few sessions to achieve their goals, others require months or longer. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, I am confident that together we will work to achieve the best possible results for you.

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Social Worker Examiners can be reached at 1560 Broadway, Suite 1350, Denver, CO 80202. (303) 894-7800. As to the regulatory requirements applicable to mental health professionals; a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their 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. A Licensed Social Worker must hold a masters 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 Certified Addition Counselor I (CACI) must be a high school graduate, and complete required training hours and 1,000 hours

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of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addictions Counselor must have a clinical master's degree and meet the CAC III requirements. A registered psychotherapist is a psychotherapist listed in the Sate's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the sate and is not required to satisfy and standardized educational or testing requirements to obtain a registration from the state.

You are entitled to information about the methods of therapy I use, the techniques, the duration of therapy (if it can be determined) and the fee structure. You have the right to terminate therapy whenever you choose and may seek a second opinion at any time.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social or personal relationship. Our contact will be limited to the sessions you arrange with me. Please do not invite me to social gatherings, offer me gifts or ask me to relate to you in any other context than our counseling services.

You will learn more about me as we work together, however, this is a professional relationship and sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder. Their address and telephone number:

> Mental Health Section of the Division of Registrations
> 1560 Broadway, Suite 1350, Denver, CO 80202
> (303) 894-7800

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, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

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FEE STRUCTURE AND OFFICE POLICIES

Sessions are 50 minutes in duration.

In return for a fee of $150 per session, I agree to provide counseling services to you. The fee for each session will be due and must be paid at the beginning of each session. Please make checks out prior to the session so that our time may be used focusing on your therapy. Cash, check, or credit cards are acceptable forms of payment.

Phone calls and meetings outside my office are also billed at $150 per hour and are billed in 15 minute increments after the first 15 minutes; this will include travel time to and from meetings. If necessary, a retainer fee will be collected prior to the meeting.

In the event that you will be unable to keep an appointment, you must notify me 24 hours in advance. Otherwise, you will be responsible for paying in full for the missed session.

Please be aware that health insurance companies require that I diagnose you with a mental health condition before they will agree to pay a reimbursement. Many conditions for which people seek counseling do not qualify for reimbursement. If a mental health diagnosis is made it becomes a permanent record of your insurance. If a mental health diagnosis is appropriate in your case, I will inform you of the diagnosis and what that means for you.

If you are applying for Victim's Compensation benefits, you are responsible for completing the initial application and providing insurance information. I will complete a treatment plan and submit a request for benefits to the appropriate compensation board. When using Victim's Compensation funding, missing appointments without 24-hours advance notice are billed to you in the amount of $150, not to the Victim's Compensation Board.

My office hours are 8:00 a.m. to 6:00 p.m. Monday thru Thursday. Sessions are by appointment only. Please direct all calls to the office number 720-898-4800. After hours voicemail is available 24 hours a day. All calls will be returned as promptly as possible, however, if you have an emergency or are in need of immediate help please call 911 for assistance with your emergency or go to the nearest hospital.

My practice is not related to any other therapist in my building and I do not have a receptionist. All inquiries are made to me in person or by phone. There may, however, be occasion for me to discuss your situation with a colleague to assist me in giving you the best professional help. If I discuss your case with a colleague your name is not used and other information is kept as general as possible to ensure your confidentiality.

I have received HIPAA information _____ (Initial)

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THERAPY FOR MINOR CHILDREN

By affixing my signature to this document, I hereby authorize Fara Murata, LCSW to treat my child/ children listed here. ___ I have full custody and decision-making rights. ____ I have joint custody with joint decision-making rights. I will provide a copy of my divorce paperwork, if applicable
.

CHILD _____ D.O.B. _____

CHILD _____ D.O.B. _____

CHILD _____ D.O.B. _____

AGREEMENT

I understand and agree that regardless of insurance or Victim's Compensation status, I am ultimately responsible for the balance of my account for any professional services rendered.

I have read the preceding information, and it has been given verbally, and I understand my rights as a client and I agree to abide by such policy.

_____ _____
Client (Parent or relationship/authority to consent) Date

_____ _____
Client (Parent or relationship/authority to consent) Date

_____ _____
Therapist Date