

**Craig A. Knippenberg, LCSW, M.Div., P.C.  
Knippenberg, Patterson & Associates**

Child, Marital, Individual & Pastoral Counseling  
Specializing in Group Therapy & Neurobehavioral Disorders

## **DISCLOSURE STATEMENT AND FINANCIAL AGREEMENT**

Colorado law requires that the following information be provided to all clients.

The practice of licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies. Concerns or complaints regarding the practice of psychotherapy may be directed to the Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1350, Denver, CO 80202. Phone: 303-894-7800.

A separate addendum to this disclosure, which identifies your therapist's training and license, will be provided to you.

You are entitled to receive information about your therapist's methods of therapy, techniques used, the duration of therapy (if known), and fee structure. You may seek a second opinion from another therapist or terminate this therapy at any time.

You should know that in a professional relationship, sexual intimacy is never appropriate and should be reported to the Department of Regulatory Agencies, mental health section.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. There are exceptions to the general rule of legal confidentiality. Some of these exceptions are listed in the Colorado Revised Statute 12-43-218. There are other exceptions that I will attempt to identify to you as the situation arises during therapy. Examples of such exceptions are when the client is an imminent danger to self or others, or when there is suspected child abuse or neglect.

You should know that Craig A. Knippenberg, LCSW, and/or \_\_\_\_\_ will provide your therapist with \_\_\_\_\_ supervision or \_\_\_\_\_ consultation. As such, information regarding your case will be available to him/her. Information regarding your case will also be provided to other staff members of Knippenberg, Patterson and Associates for administrative and/or clinical care coordination purposes.

You will be billed at the time services are rendered. Any balance not paid after thirty days will be assessed a service charge at the rate of 1.5% per month. In the event our billing efforts fail, we will send delinquent accounts to a collection agency, with instructions to follow their usual course of action. By signing this agreement you are agreeing to this procedure.

Sessions are generally 45 to 50 minutes, for individual/family sessions and 90 to 150 (in summer) minutes for group sessions. This time is reserved for you. Missed appointments with less than 24-hour notice will be charged at the therapy session rate.

Mailing:  
2833 S. Colorado Blvd. #2445 Denver, CO 80222  
Voice Messaging: 303-756-4924  
Fax: 303-758-3515

Clinical:  
7531 S. Kendall Blvd. Littleton, CO 80128  
2833 S. Colorado Blvd. #2445 Denver, CO 80222  
4101 E. Hampden Ave. Denver, CO 80222

[www.craigknippenberg.com](http://www.craigknippenberg.com)

# Knippenberg, Patterson & Associates

## Group, Family and Individual Counseling

Specializing in Child & Adolescent Neurobehavioral Disorders

Telephone calls will be returned as promptly as possible. If your call is an emergency, please state this when you are calling. Telephone consultations lasting more than 10 minutes will be charged at therapy session rate.

Our standard and customary fees are \$150.00 per individual/family session; \$70.00 per 90-minute group session; and \$110.00 per 150-minute group session. Fees for other services and out of office procedures may vary. I understand that the fee for my service is \$\_\_\_\_\_ per \_\_\_\_\_\*.

I/We will receive counseling beginning \_\_\_\_\_.

I understand that payment is due at the time of service unless other arrangements have been made.

Special Arrangements:

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I have been informed of my therapist's degrees, credentials and licenses. I have also read the preceding information and understand my rights as a client. I agree that I am financially responsible for all services received. In the event I am seeking services for a child, I also hereby attest that I have the authority to consent for such services for said child.

\_\_\_\_\_  
Responsible Party (Printed Name)      Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Responsible Party (Signature)      Date

\_\_\_\_\_  
Credentials

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Licensure

Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Supervisor

Contact Numbers: \_\_\_\_\_

Home \_\_\_\_\_

Work \_\_\_\_\_

Cell \_\_\_\_\_

\*Rates may periodically be subject to change.