

Attention & Learning Assessment Services PLLC

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Welcome to Attention and Learning Assessment Services!

I am Stephanie Sharp, PhD, a licensed psychologist with years of training and experience conducting evaluations and evidence-based treatments with individuals encountering learning, attention, social and behavioral difficulties. I believe that every individual is unique and remarkable in their own way. Through skilled assessment, I can provide diagnostic clarity, share helpful insights around areas of personal strength and challenge, while also making recommendations that can minimize struggles, optimize functioning, and promote success.

DISCLOSURE STATEMENT & POLICIES

REGULATION OF MENTAL HEALTH PROFESSIONALS IN COLORADO:

1. Attention and Learning Assessment Services PLLC's ("ALAS") contact information is 2221 E. Arapahoe Road #2173, Centennial, CO 80122, 720-213-8199. The mental health professional at ALAS is Stephanie Sharp, PhD. Stephanie Sharp, earned her Doctorate degree in School Psychology from the University of Northern Colorado in 2009. She has received pre-doctoral and post-doctoral training in school psychology, clinical psychology, neuropsychology and rehabilitation psychology with school and pediatric medical settings. Stephanie Sharp is a Licensed Psychologist in the State of Colorado, License No. 3690, who in addition to private practice, works at Children's Hospital of Colorado as the lead psychologist on the Multidisciplinary Outpatient Rehabilitation Evaluation team (MORE) in the Department of Rehabilitation, conducting comprehensive evaluations for children with complex medical and developmental needs.

2. Everyone twelve (12) years and older or emancipated youth must sign this disclosure statement. A parent or legal guardian with the authority to consent to evaluation services for his or her minor child/ren, must sign this disclosure statement on behalf of his or her minor child under the age of twelve (12) years old. If the parent or legal guardian is the responsible paying party, the parent or legal guardian must sign this disclosure statement. Please note that in cases of divorce, I will need a letter indicating legal custody status. In the case of joint legal custody, permission must be provided in writing by both parents. Unless there is legal documentation to the contrary, either parent may request access to the child's information. Please note that I do not perform custody evaluations and therefore do not make custody or visitation recommendations. This disclosure statement contains the policies and procedures of ALAS and is HIPAA compliant. No medical, educational, psychological, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law and Federal regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

3. The Colorado Department of Regulatory Agencies ("DORA"), Division of Professions and Occupations ("DOPO") has the general responsibility of regulating the practice of Licensed Psychologists. The agency within DORA that specifically has responsibility is the Mental Health Section, 1560 Broadway, Suite #1350, Denver, CO 80202, (303) 894-2291 or (303) 894-7800; DORA_MentalHealthBoard@state.co.us. The State Board of Psychologist Examiners regulates Licensed Psychologists, and can be reached at the address listed above. Clients are encouraged, but not required, to resolve any grievances through ALAS's internal process.

4. You, as a client, may revoke your consent to treatment or the release or disclosure of confidential information at any time in writing and given to your psychologist.

5. Levels of Psychotherapy Regulation in Colorado include Licensing (requires minimum education, experience, and examination qualifications), Certification (requires minimum training, experience, and for certain levels, examination qualifications), and Registered Psychotherapist (does not require minimum education, experience, or examination qualifications.) All levels of regulation require passing a jurisprudence examination . A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

CLIENT RIGHTS AND IMPORTANT INFORMATION:

As a client you are entitled to receive information from me about my methods of assessment and evaluation, the duration of your assessment, if I can determine it, and my fee structure. Please ask if you would like to receive this information.

Fees:

1. My fee structure, services, and fee policy are outlined as follows:

- a. Evaluation costs typically range from \$2,000 - \$4,000 and includes intake/interviews, record review, rating scale data collection and scoring, test administration, scoring, and interpretation, evaluation report write-up, and the evaluation feedback session. For additional services (including further consultation), the hourly fee is \$200.00.
- b. It is the policy of my practice to collect half of the assessment fee at the initial evaluation date and to collect the second half of the assessment fee at the time of the evaluation feedback meeting, unless you make other arrangements for payment and we both agree to such an arrangement. In addition, I request that you fill out a “Credit Card Authorization” form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.
- c. **I am not** a Medicaid provider. If you have Medicaid coverage that includes mental health or assessment services, **I am not** able to offer mental health or assessment services to you.
- d. Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees I may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is \$600.00 per hour.

Evaluation Process:

2. The goal of the evaluation is to provide you with a comprehensive understanding of the client's functioning and recommendations for ways of supporting the individual's specific needs. The evaluation process typically consists of a clinical interview (with the client and/or caregivers), collateral contacts, review of relevant academic and/or medical records, standardized testing and behavioral observation. The evaluation process involves a clinical interview, one or two testing sessions with the client and a feedback session. With your permission and if applicable, information from the client's teacher and other professionals involved in the client's care may be obtained (e.g. teacher, therapist, physician). After the evaluation is complete, a written report will be generated. Please be aware that the written report is typically completed 2-4 weeks after the feedback session. Written reports are sent to the client and/or parents/caregivers as applicable. Written reports will not be released until final payment is received.

Restrictions on Uses:

3. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a); however, ALAS is not required to agree to a restriction request. Please review ALAS's Notice of Privacy Policies for more information.

Second Opinion and Termination:

4. You are entitled to seek a second opinion from another psychologist or terminate the evaluation process at any time.

Sexual Intimacy:

5. In a professional relationship sexual intimacy between a psychologist and a client is **never** appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Psychologist Examiners.

Confidentiality:

6. Generally speaking, the information provided by the client and to a patient by the Licensed Psychologist is legally confidential. If the information is legally confidential, the psychologist cannot be forced to disclose the information without the client's consent or in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

7. There are exceptions to this general rule of legal confidentiality. These exceptions are listed in the Colorado statutes, C.R.S. §12-43-218. You should be aware that provisions concerning disclosure of confidential communications does not apply to any delinquency or criminal proceedings, except as provided in C.R.S § 13-90-107. There are additional exceptions that I will identify to you as the situations arise during the evaluation process or in our professional relationship. For example, I am required to report child abuse or neglect situations; I am required to report the abuse or exploitation of an at-risk adult or elder or the imminent risk of abuse or exploitation; if I determine that the client or care providers are a danger to self or others, including those identifiable by their association with a specific location or entity, I am required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if the client or caregiver becomes gravely disabled, I am required to report this to the appropriate authorities. I may also disclose confidential information in the course of supervision or consultation in accordance with my policies and procedures, in the investigation of a complaint or civil suit filed against me, or if I am ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if the client or caregiver should communicate any information involving a threat to self or to others, I may be required to take immediate action to protect the client, caregiver, or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, I cannot guarantee that those communications will be kept confidential and/or that a third-party may not access our communications. Even though I may utilize state of the art technology systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out ALAS's Consent for Communication of Protected Health Information by Unsecure Transmissions.

Additionally, all information obtained during the evaluation process is eligible to be submitted in your final evaluation report. As such, confidentiality cannot be guaranteed. The final report will be given to all adult clients (or to parents/legal caregivers in the case of a minor) who consented to the evaluation process and to any collateral professionals associated with the client if an **Authorization for the Release of Information** form is signed by the client, parent or legal guardian indicating that said person has the right to receive or review the report. This psychologist cannot ensure that confidentiality of the report is maintained by anyone who is in receipt of the report once it has been authorized to be released to the recipient.

Extraordinary Events:

8. In the case that I become disabled, die, or am away on an extended leave of absence (hereinafter "extraordinary event,") the following Mental Health Professional Designee will have access to my client files. If I am unable to contact you prior to the extraordinary event occurring, the Mental Health Professional Designee will contact you. Please let me know if you are not comfortable with the below listed Mental Health Professional Designee and we will discuss possible alternatives at this time.

NAME: Dr. Laura Santerre-Lemmon
ADDRESS: 2501 N. Dallas St., Suite 274, Aurora, CO 80010
TEL: 303-325-6481

The purpose of the Mental Health Professional Designee is to continue your care with the least amount of disruption as possible. You are not required to use the Mental Health Professional Designee for services, but the Mental Health Professional Designee can offer you referrals and transfer your client record, if requested.

Maintenance of Client Records:

9. As a client, you may request a copy of your Client Record at any time. In accordance with the Rules and Regulations of the State Board of Psychologist Examiners, I will maintain your client record (consisting of disclosure statement, contact information, reasons for therapy, notes, and/or test data, etc.) for a period of seven (7) years after termination or the date of our last contact, whichever is later. I cannot guarantee a copy of your Client Record will exist after this seven-year period.

Electronic Records: (without electronic records)

10. ALAS may keep and store client information electronically on Stephanie Sharp, PhD's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect the record, ALAS may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. ALAS may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

ALAS may also use electronic backup systems either by using external hard drives, thumb drives, or similar methods, this includes the email service provider ALAS uses. The email service provider ALAS uses is Gmail. This helps prevent the loss or damage of electronically stored information. ALAS may maintain the security of the electronically stored information through encryption and passwords.

It may be necessary for other individuals to have access to the electronically stored information, such as email service provider 's workforce members , in order to maintain the system itself . Federal law protecting the electronically stored information extends to these workforce members . If you have any questions about the security measures ALAS employs, please ask.

AS A CLIENT:

You as a Client agree and understand the following:

1. I understand that ALAS may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with ALAS's Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in ALAS's Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my therapist may communicate with me via this method.

3. I understand that there may be times when my psychologist may need to consult with a colleague or another professional, such as an attorney or supervisor, about issues raised by me during the evaluation process. My confidentiality is still protected during consultation by my psychologist and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my psychologist permission to consult as needed to provide professional services to me as a client. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides a colleague, supervisor or attorney retained by my psychologist.

4. I understand that my psychologist does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any Social Media. Any such request will be denied in order to maintain professional boundaries. I understand that ALAS has, or may have, a business social media account page. I understand that there is no requirement that I "like" or "follow" this page. I understand that should I "like" or choose to "follow" ALAS's business social media page that others will see my name associated with "liking" or "following" that page. I understand that this applies to any comments that I post on ALAS's page/wall as well. I understand that any comments I post regarding evaluation and assessment work between my psychologist and I will be deleted as soon as possible. I agree that I will refrain from discussing, commenting, and/or asking therapeutic and/ or assessment related questions via any social media platform. I agree that if I have a therapeutic or assessment comment and/or question that I will contact my psychologist through the mode I consented to and **not** through social media

5. I understand that if I have any questions regarding social media, review websites, or search engines in connection to the evaluation process , I will immediately contact my psychologist and address those questions.

6. I understand my psychologist provides non-emergency evaluation/ assessment services **by scheduled appointment only**. If, for any reason, I am unable to contact my psychologist by the telephone number provided to me, 720-213-8199, and I am having a true emergency, I will call 911, check myself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. **If I must seek after-hours treatment from any counseling agency or center, I understand that I will be solely responsible for any fees due.**

7. **I understand that I am legally responsible for payment for my evaluation services and that all professional services are rendered and charged to me.** Depending on the referral question and the

client's medical/developmental history, your health insurance company may cover a portion of the cost of the evaluation. Please check your coverage carefully. If requested, I can provide a detailed invoice to you to submit to your insurance company in order to request reimbursement for the testing fees. I understand that I remain solely responsible for payment even if, for any reason, the insurance company, HMO, third-party payer, etc. does not provide compensation. I also understand that signing this form gives permission to my psychologist to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my evaluation funding source regarding payment. I understand that my insurance company may request information from my psychologist about the evaluation services I received which may include but is not limited to: a diagnosis or service code, description of services, testing results, evaluation report, recommendations and in some cases my psychologist's entire client file. I understand that once my insurance company receives the information, I or my psychologist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. I understand that I may request from my psychologist a copy of any report ALAS submits to my insurance company on my behalf.

8. I understand that this form is compliant with HIPAA regulations and no medical or assessment information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

9. I understand that if I have any questions about my psychologist's methods, techniques, or testing protocols, fee structure, or would like additional information, I may ask at any time during the evaluation process.

10. In order to protect the integrity of the evaluation process the professional relationship must remain solely that of psychologist and client. This means that my psychologist cannot be my friend, cannot have any type of business relationship with me other than the professional relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for testing); cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client, and cannot hold the role of psychologist to her relatives, friends, the relatives of friends, people known socially, or business contacts.

11. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my therapist has a right to charge my credit card on file, or my account, for the full amount of my session.

12. I also affirm, by signing this form, I am at least twelve (12) years old and consent to evaluation or assessment services here at ALAS or that I am the legal guardian and/or custodial parent with the legal right to consent to evaluation for any minor child/ren who is under the age of twelve (12), for whom I am requesting evaluation services here at ALAS.

13. I understand that if I am consenting to evaluation and assessment services for my minor child/ren that my psychologist may request that I produce the Court Order Custody Agreement and/or Parenting Plan that grants me the authority to consent to evaluation services for my minor child. Further, I understand and agree to keep my psychologist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority. I understand that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit my psychologist from providing evaluation/assessment services to my minor child/ren. I understand that it is beyond the scope of my psychologist's practice to provide custody recommendations. Any request for custody recommendations will be denied. A Court is able to appoint professionals with the expertise to make such recommendations.

14. By signing this form, I affirm that I am fully informed of the evaluation services I am requesting and that ALAS is providing, and grant my consent to receive such evaluation services.

My signature below affirms that the preceding information has been provided to me in writing by my psychologist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy . I understand my rights as a client and should I have any questions , I will ask my psychologist.

Client Name

Client Signature (if age 12 or older)

DATE

If client is a child:

Parent/Legal Guardian Signature (Please specify Relationship to Client)

DATE

Parent/Legal Guardian Signature (Please specify Relationship to Client)

DATE

 , Ph.D.

Stephanie Sharp, PhD.

DATE