Gregory A. Thwaites, PhD, PLLC
Clinical Neuropsychologist

2026 Caribou Dr., Ste 101
Fort Collins, CO 80525
Office (970) 744-4965
Fax (970) 666-4527

Disclosure Statement

Doctor: Greg Thwaites, Ph.D.

Credentials: Ph.D. at Colorado State University
Pre-doctoral internship at Denver General Hospital
Post-doctoral fellowship in Neuropsychology at Duke University Medical Center

Licensure: Clinical Psychologist, CO 2049

Patient Rights: In accordance with Colorado state law, we would like to provide you with the following information:

1. Information revealed to you in the course of our work is legally confidential. The exceptions to this are as follows:
   a. If you are imminently dangerous to yourself or others, or involved in child abuse, mental health professionals are legally bound to take steps to protect the jeopardized person(s).
   b. If you are in the Worker's Compensation system, be aware that you have already waived confidentiality. If this is the case, all medical records (including the ones at this facility) may be available to your Insurer and other Health Care providers. If you consent to undergo an evaluation regarding claims in this system, be aware that you are giving your consent for a report to be prepared and forwarded to your Insurer and to your referring physician.
2. You are always free to receive information about methods of therapy, the credentials of your therapist, the duration of therapy if known, and the fee structure. Dr. Thwaites is qualified to receive payments from many insurance companies. The method of payment should be determined during the first session. Please feel free to ask any questions regarding payments and insurance.
3. You may seek a second opinion from another clinician, and you may terminate evaluation or treatment services at any time. You should also know that in a professional relationship sexual intimacy is never appropriate and should be reported to the grievance board.
4. The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Colorado State Board of Regulatory Agencies. Any questions, concerns, or complaints regarding the practice of mental health may be directed to the State Board at this address: State Grievance Board, 1560 Broadway, Suite 1340, Denver, Colorado 80202. The phone number is (303) 894-7766.

I have been informed of my doctor's degrees, credentials, and licenses.
I have also read the preceding information and understand my rights as a client.

_____
Client Signature Date

_____
Witness Signature Date

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Authorization to Release and Request Information

I, _____, Date of Birth: _____
First Name Middle Last Name

Hereby authorize the Greg Thwaites, PhD, PLLC to Release all records, reports, psychological test data, attendance information, notes, and correspondence to the parties listed below in either written or verbal form. I further authorize the Greg Thwaites, PhD, PLLC to request all records, reports, psychological test data, attendance information, notes and correspondence from the party or parties listed below in either written or verbal form.

Release and request information from:

_____ _____

_____ _____

_____ _____

_____

I hereby certify that this Authorization to Release and Request information has been made voluntarily, and I further release Greg Thwaites, PhD from all liability for releasing such information/ Copies of this Authorization or my signature thereon may be utilized with the same effectiveness as an original.

_____ _____ _____
(Signature of Client) (Date) (Witnessed by)

If the client is under the age of 15 years, or has a legal guardian appointed by the Court, this Authorization must be signed by the client's parent or legal guardian.

_____ _____ _____
(Signature of Parent or Guardian) (Date) (Witnessed by)

NOTICE TO WHOM INFORMATION IS GIVEN: The information disclosed by this authorization comes from records whose confidentiality is protected by law. These regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains.

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officemanager@gregthwaites.com

Audio/Video Policy Acknowledgement

In order to safeguard the privacy of all of its patients, Dr. Gregory Thwaites PhD, PLLC prohibits any audio or video recording or the taking of any photographs (digital or otherwise) at our office or anywhere on the premise. Individuals who violate this policy may be asked to hand over or destroy the recordings, including any postings of the recording that have been shared.

By signing below I certify that (a) I am the patient, or an agent duly authorized to execute this acknowledgement on behalf of the patient; (b) I have read the policy stated above, and (c) I accept and acknowledge the above policy.

Patient: _____
Print Name Date of Birth Date

Patient Signature: _____ Witness: _____

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FINANCIAL POLICY

Your primary insurance will be billed for you. If you have any secondary insurance, that policy will be billed after the primary insurance has made payment.

In the event that the primary and/or secondary insurance policy does not make payment for the services, the patient will be responsible for the charges unpaid by the insurance.

Our office does not know what every insurance company's payment policies are, if you have any questions about your policy, phone the member benefits for your insurance company.

I understand and agree to the financial policy for Dr. Greg Thwaites.

_____ _____

Patient Signature **Date**