KESMA Flame Lily LLC

Child-Adolescent Intake

Please provide the following information about your child:

Child's Full Name:	Nickname:
Birth Date:	Today's Date:
Child's Address:	Phone:
Parent(s) names or primary guardian:	Parent(s) contact numbers: Home: Cell: Work:
In case of emergency, who may I contact on your behalf?	Name:
Phone number:	Relationship:

Education History

What school does your child attend:	Teacher's Name:
Current Grade:	Has your child ever repeated a grade? YES/ NO If so which one(s)
Favorite Subject:	Least Favorite Subject:
Does your child receive special education service? YES /NO	Does your child receive tutoring? YES/ NO
Is your child in a gifted/talented/honors program? YES/ NO	Does your child like school? YES/ NO
Has your child experienced any of the following at school? (please circle all that apply) Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, drug/alcohol, poor attendance, behavior problems, detention, poor grades	
Has your child been the victim of bullying or bullied other children? YES/ NO.	

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If yes, please describe:
Please, use the space to provide any other additional information regarding your child's education or developmental history that you find significant:

Medical History

Pediatrician's Name:	Phone:
Is child under the care of another medical specialist? YES/NO If yes, type of specialist _____	Phone:

Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability:	Dates:

List all medications that your child is currently taking:

Medication:	Dosage:	Treating:

Therapy / Psychiatric Experience

Is your child *currently* seeing another therapist? YES / NO

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If yes, who are you seeing?			
Has your child ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason
Has your child ever had a psychiatric hospitalization? YES/ NO			
If yes describe briefly and indicate dates and circumstances			

Is your child under the care of a psychiatrist: YES/ NO	If yes, Psychiatrist name:
Phone:	Address:

Other History

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? YES/ NO If yes, please describe:
Has your child ever made statement of wanting to him/her self or seriously hurt someone else? YES/ NO Has he/she purposely hurt himself or another? YES/ NO If yes, to either question please describe the situation:
Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO. If yes, please explain:

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Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble? YES/NO. If yes, please describe:
Are there any behaviors that your child fails to do as often as you would like or when you would like?
Please list positive strengths of your child: (What do you like about your child? What do others like about your child?)
How would you describe your child's self-esteem?
Briefly describe your reason(s) for seeking help at this time?
What goals do you wish to accomplish during the therapy process as a parent?
What goals does your child wish to accomplish during the therapy process? (can be different than parent's response)

Family History

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Mother's Name Occupation:	Father's Name: Occupation:
Step-Mother?	Step Father?

Who does your child currently live with?

Names	Age	Relationship to child	Grade/Job

Who are your child's significant others NOT living with your child?

Names	Age	Relationship to child	Grade/Job

Are child's parents'? Married Separated Divorced Widowed (please circle one)
If parents divorced/separated please list dates:

Who in the family is your child closest too?

What are some of the strengths of your family?

Does anyone in the child's family been diagnosed with a mental illness? YES/ NO
If yes, please describe:

Is there anything else that you think would be important for me to know about your child, you, or your family?

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How did you hear about our services? Internet search? Website?

Notice of Privacy Practices

Client Name:_____

Client Date of Birth_____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on **DATE** _____

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature _____ ***Date*** _____

Client Signature _____ ***Date*** _____

Therapist Signature _____ ***Date*** _____

Client Agreement and Therapeutic Policies

Client Name:_____

Client Date of Birth_____

Introduction:

This agreement is intended to provide clients with important information regarding our professional services and business policies. This consent form will provide a clear framework for our work together and will facilitate our therapeutic relationship. Any questions or concerns regarding the contents of this agreement should be discussed with me prior to signing it.

Part I: Therapist Information

Professional Orientation:

We provide individual therapy for adults, adolescents, and children. We also provide couples therapy, family therapy, pre-marital therapy, group therapy, and parental training for clients in need of these services.

Educational/ Training Background:

We are all Licensed Therapists in the State of Minnesota and Unlicensed Therapists who are currently in training for full licensure.

Part II: Client(s) Rights

1. Every client shall have the right to considerate and respectful care.

2. Every client can reasonably expect complete and current information concerning his/her diagnosis, treatment, and prognosis in terms he/she can understand from his/her mental health professional. When it is not advisable to give the information to the client it may be available to the appropriate person on his/her behalf according to guidelines provided by Statute 144.335.

3. Every client shall have the right to know by name and specialty, if any, the therapist responsible for his/her care.

4. Every client shall have the right to expect the clinic to make a reasonable response to his/her requests.

5. Every client shall have the right to expect reasonable continuity of care. This shall include, but not be limited to, whatever appointment times the therapists are available.

6. Every client shall be fully informed of the services available in the clinic and of related charges.

7. Every client shall have the opportunity to participate in the planning of his/her treatment, and to refuse to participate in experimental research.

8. No client shall be arbitrarily referred, transferred, or terminated from the treatment program, but he may be referred, transferred, or terminated, for medical reason, for his/her welfare, or other client's welfare, or for non-payment of services unless prohibited by the welfare program's paying for the care of treatment of the client as documented in the treatment record. Reasonable advance notice of any referral, transfer, or discharge must be given to the client.

9. Every client may manage his/her own financial transactions on his/her behalf, or he/she may delegate this responsibility in accordance with the laws of Minnesota to the clinic or its representatives for any period of time.

10. Every client shall be free from mental and physical abuse, and free from chemical or physical restraints, except in emergencies or as authorized in writing by his/her physician for a specified and limited period of time when necessary to protect the client from injury to himself/herself or to others.

11. No client shall be required to perform services for the facility that are not included for therapeutic services in his/her plan of care.

12. Every client may associate and communicate privately with person of his/her choice.

13. Every client may meet with representatives and participate in activities of commercial, religious, and community groups at his/her discretion, provided, however, the activity shall not infringe upon the rights to privacy of other clients.

14. Every client shall be fully informed prior to or at the time of admission to the treatment program of the rights and responsibilities set forth in this section on all rules governing conduct and responsibility.

One of the most important rights involves confidentiality: within the limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. As your therapist, I am legally prohibited from revealing to another person that you are in therapy with me, nor can I reveal what you have said to me in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law or my professional standards.

Limits of Confidentiality:

a) Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.

b) If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person, I may warn the intended victim and notify the proper authorities.

c) If you, as a client, reveal a serious intent to harm yourself, I am ethically bound to do what I can to help maintain your safety, which may involve notifying others who may be of assistance.

d) If a judge orders my testimony or, in the context of a legal proceeding, you raise your own psychological state as an issue, I may be required to release your confidential information to the court.

In all the above cases, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities. Your confidentiality remains an *ethical priority*.

Part III: The Therapeutic Process

Benefits and Risks of Therapy:

Psychotherapy is a process in which you and I discuss a variety of issues, events and experiences for the purpose of creating positive change so you can experience your life more fully. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. There is no guarantee that therapy will yield any or all the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by you may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Please address any concerns you have regarding your progress in therapy with me.

Appointments:

Your appointment time is reserved especially for you. Cancellations must be made 24 hours in advance; otherwise, you are responsible for a $100 fee. After 2 missed appointments you will be required to pay in full in advance for your next scheduled appointments. Regular attendance is recommended to ensure continuity and to enhance the effectiveness of the therapy.

E-Mail, Cell Phones, Computers and Faxes:

It is very important to be aware that computers, E-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent by myself are not encrypted. Faxes can easily be sent erroneously to the wrong address. I only use computers that are equipped with a firewall, a virus protection and a password. *Please do not use e-mail or faxes for emergencies.*

Paperwork:

In order for any paperwork to be filled out on your behalf, a minimum of 3 consecutive sessions is required before any paperwork is done. No Exceptions. If you are an inactive client (either have not been seen by your therapist in 20 consecutive days and have not communicated about your absence OR have made your own decision to drop out of therapy against the recommendation of the therapist OR therapy was terminated as

agreed upon collaboratively between you and your previous therapist) and wish to return as an active client, you must be seen for a minimum of 3 consecutive sessions before any paperwork is done on your behalf.

Records and Administrative Services:

I may take notes during session and will also produce other notes and records regarding treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Should you request a copy of my records, such a request must be made in writing. I reserve the right under Minnesota law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I will maintain client's records for seven years following termination of therapy. If a client is a minor**,** records will be maintained for ten years after minor's eighteenth birthday. However, after 7-10 years, your records may be destroyed in a manner that preserves your confidentiality. Processing time for records is 30 days, if you need them sooner please make us aware at the time of the request. **All accounts must be paid in full before any records will be sent.**

Fees/Insurance

INSURANCE BILLING (Please call 612-440-0914 to update insurance or use client portal)

We are in-network providers for HealthPartners, Preferred One, Cigna, Medical Assistance, Ucare, Optum, UnitedHealthCare, Medica, Hennepin Health/Metropolitan Health and Blue Cross Blue Shield. As a courtesy to you, we work directly with your insurance company.

You must notify us in advance of your first appointment if you intend to use an Employee Assistance Program (EAP). Once services have been provided under insurance, we will not bill your EAP.

Once your appointment has been scheduled, we will verify your coverage and obtain any necessary authorizations. Verification of coverage is not a guarantee of claim payment. Coverage is subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company. It remains your responsibility to understand your plan's limitations, deductibles, and exclusions. For benefit coverage questions, please call the customer/member service number on the back of your insurance card. We have no authority to make specific representations to you regarding coverage of services.

It is your responsibility to provide us with updated information when your insurance policy changes, or your coverage terminates. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for paying the amount of the denied claim.

If you attend any appointment without verification of your current insurance coverage, you are responsible to pay the private pay fee for services at the time of your visit.

There may be instances in which you will need to communicate directly with your insurance company to ensure a smooth billing process. If your insurance requests information regarding Coordination of Benefits (CoB) or

Pre-existing Conditions, please promptly return any forms or call your insurance company directly to follow up. Once they request this information from you, all claims deny and become your full financial responsibility until you provide it. Please call us at 612-440-0914 to let us know you have resolved any CoB or Pre- existing Condition requests so we can have your insurance reprocess the denied claims immediately.

It is completely up to the therapist if they agree to do the paperwork. We have the right to choose not to do paperwork requests.

ACCOUNT RESPONSIBILITY

Because we are a "fee for service" provider, billing statements from Re-Connect My Life Consulting & Counseling will NOT automatically be sent. Should you need a statement or itemized receipt, please inform your therapist, and we will provide this for you upon request.

Per your agreement with your insurance company, it remains your responsibility to immediately pay any copayments, deductibles, coinsurances or other amounts your insurance carrier determines as payable by you. This payment is to be collected by calling the office at 612-440-0914 or mailing a check to 2800 Freeway Blvd #106, Minneapolis, MN 55430.

We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract, we have with your insurance company.

Cost estimation tools provided by your insurance company allow the collection of coinsurance and deductible amounts up front a t the time of service rather than waiting until after the claim is processed. This collected payment is based on an estimate of your out-of- pocket costs for services provided. Actual coverage and member liability amounts are determined once the claim is processed and you receive an explanation of benefits (EOB). Any overpayments will be applied to ongoing balances or refunded within 60 days of claim processing. Any underpayments must be paid by mail, online at our website, or at your next scheduled appointment (if scheduled appointment occurs within 1 week of receiving your EOB).

You are responsible for charges not eligible and/or covered by your medical insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you regardless of any claim submitted.

Should you default on any payment obligations, we reserve the right to forward your information to collections, and an additional 30% may be assessed to cover the costs of this action.

We are not obligated to provide continuing services in the event that Levan Counseling & Consulting Services is named as a creditor in any bankruptcy filing.

MISSED APPOINTMENTS

Levan Counseling requires a 24-hour notice when cancelling an appointment. This will allow us to schedule the time for someone else. Please note: **IF YOU DO NOT ATTEND A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN 24-HOUR NOTICE, YOU WILL BE CHARGED A $100 FEE.** Your

insurance cannot be billed for missed appointments. At the discretion of LCCS your services may be discontinued due to excessive failed appointments or late cancels.

FEES FOR SERVICES NOT BILLABLE TO INSURANCE

- Medical Records Processing Fee = $25 per request
- Copies of Medical Records Pgs 1-20 = $1 per page
- Copies of Medical Records Pgs 21-50 = $0.50 per page
- Copies of Medical Records Pgs 51+ = $0.30 per page
- Professional Consultation Services (min 30 min) = $150
- Phone calls, letters and reports (per 15 min) = $30
- Court Appearances*** (per 15 min) = $250

MAKING PAYMENTS

- Online Client Portal
- Check or Money Order or Cash
- Remit all payments to main office Levan Counseling 2800 Freeway Blvd #106, Minneapolis, MN 55430.

There is a fee of $40 for checks returned for insufficient funds. Minnesota Care Tax will be added where applicable, and you agree to be held responsible for these fees.

Divorce/Custodial Situations

The parent or guardian who brings the child in for care will be considered the responsible party and will receive all billing statements and letters. Any court-ordered financial arrangements must be worked out between the parents of the children.

1. I agree BY ENTERING into therapy with Levan Counseling & Consulting Services I will pay the full fee at each session. If I am late to a session, the length of the session may be shortened, and I agree to pay for a full session**.

Fee Structure: per hour

Individuals (Child/Adult) $ 200.00

Couples/Family Session $200.00

2. A 24 - hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a $100 missed appointment fee. I understand that this will be my responsibility, not that of the third-party payer.

3. I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

4. I understand that I may pay for my sessions using a major credit card, personal check or cash at the time of service.

Attestation for Consent

By signing this document, you understand that this becomes your electronic signature for the following forms: Initial Treatment Plan and Updated Treatment Plans. The provider will ask for your verbal consent after reviewing the forms with you.

LCCS may contact you via text message or email. LCCS is not financially liable for any charges you incur from your service provider(s).

I hereby acknowledge that LCCS's HIPAA/Notice of Privacy Practices and Client or Consumer Rights Handout, procedures for reporting alleged violations of client's rights and grievance procedures have been made available to me.

I HAVE READ AND AGREE TO THE ABOVE AND HEREBY GUARANTEE PAYMENT OF ALL CHARGES FOR SERVICES WITH THE FINANCIAL ARRANGEMENTS OF LCCS.

CONSENT FOR SERVICES

Thank you for reviewing this information and please feel free to discuss any of this information with me.

My/Our signature(s) on this disclosure statement indicates I/We have read and understood the conditions of the consultation services outlined. I/We have had the opportunity to clarify any questions and agree to the terms described above before receiving services. I/We have been provided with a copy of this disclosure statement.

Client Signature _____***Date*** _____

Client Signature _____***Date*** _____

Therapist Signature _____***Date*** _____

Informed Consent for Psychotherapy

Client Name:_____

Client Date of Birth_____

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Client Signature _____ ***Date*** _____

Client Signature _____ ***Date*** _____

Therapist Signature _____ ***Date*** _____