

4. Medical Information

Primary Care Physician: _____ Phone: _____

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, convulsions, seizures and/or any other medical conditions you have had since childhood.

Do you have any allergies? Yes No

If yes, please list them: _____

Please list all prescribed and over the counter medications, drugs or other substances (vitamins, herbs) you take or have taken in the last year.

What type of physical exercise do you get on a weekly basis?

Do you restrict your eating in any way? Yes No

If yes, how & why? _____

Do you have any problems sleeping? Yes No

If yes, please explain. _____

How much beer wine or hard liquor do you consume on average each week? _____

How much tobacco do you smoke or chew each week? _____

Do you have a history of drug and/or alcohol problems? Yes No

If yes, please provide details about your use of drugs or chemicals, such as amounts, how & why you used them and treatment, if any.

5. Family & Social Information

Please fill in the following information for significant family members.

Relative	Name	Age	Living/ Deceased	Illnesses	Occupation
Spouse or Significant Relationship -married – yes or no -how long have you been together &/or married ? _____					
Children &/or stepchildren					
Father					
Mother					
Stepparents					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					
Other Significant Family members/relationships					

Please describe you parents' relationship with each other. _____

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Please describe your relationship with each parent. _____

Please describe any, drug or alcohol use and mental or emotional difficulties that run in your family.

Please describe your relationship with your brothers and/or sisters. _____

Please describe your relation with your present spouse or partner. _____

Please describe your relationship with your children or stepchildren. _____

Were you ever abused?

Yes No

If yes, please explain the circumstances, include the age you were when the abuse started, if it was emotional or physical, by whom and the effects on you.

Are you currently involved in any legal cases or lawsuits?

Yes No

If yes, please explain. _____

Were you ever arrested or charged with a crime.

Yes No

If yes, please explain. _____

Thank you for your time in completing this form.
Once completed this is a strictly confidential patient medical record.

Adult Checklist of Concerns

Name:

Date:

Please mark all of the items below that apply, and feel free to add any others at the bottom under “Any other concerns or issues.” You may add a note or details in the space next to the concerns checked.

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension

(cont.)

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Adult Checklist of Concerns (p. 2 of 2)

- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also "Career concerns . . .")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

-
-

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

Once completed this is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the first appointment forms and I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel within 48 hours or do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Printed name

Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

Copy accepted by client Copy kept by therapist

Once signed this is a strictly confidential patient medical record. Rediscovery or transfer is expressly prohibited by law.

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Email: DrPerrymore@gmail.com

Agreement to Pay for Professional Services

I request that the therapist named below provide professional services to me or to _____, who is my _____, and I agree to pay this therapist's fee of \$ **145.00** per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person, by phone, email or certified mail that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons may make payments on my (or this client's) account.

I have also read and signed this therapist's informational forms (Consent to Treatment, HIPPA, Confidentiality, Information patients have a right to know, the limits of confidentiality via email) and agree to act according to everything stated there, as shown by my signature below and on each of those forms.

Signature of client (or person acting for client)

Date

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

Copy accepted by client Copy kept by therapist

HIPAA "Notice of Privacy Practices"

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS
AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

As a rule, I will disclose no information obtained from your contacts with me, or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency,], and some required by law. If you wish to receive mental health services from me, then under the Federal HIPAA regulations, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I. Uses and Disclosures Requiring Authorization or Consent

HIPAA allows health care providers to use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes. **In my own practice however, I do not disclose information routinely in these circumstances, so this will require your permission in advance, either through your consent at the onset of our relationship** (by signing the attached general consent form), **or through your written authorization at the time the need for disclosure arises.** You may revoke your permission to release PHI, in writing, at any time, by contacting me. If there is an emergency and I cannot ask your permission, I am allowed to share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you. Mental Health Medical Records is the term used for my formal record of the services provided to you, and these contain the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. (Under HIPAA Regulations, such notes are given a greater degree of protection than the PHI or formal record, because they are considered my own private communication. However, Pennsylvania law does not protect such records from subpoena.)

II. Possible Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances by policy, or if legally required:

- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Pennsylvania law to report the matter immediately to the Pennsylvania Department of Public Welfare.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Pennsylvania law to immediately make a report and provide relevant information to the Pennsylvania Department of Health.
- **Health Oversight:** Pennsylvania law requires that I report misconduct by a health care provider of my own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report that you are in treatment if I believe that your condition places the public at risk. Pennsylvania Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
- **Court Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or if a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court.
- **Serious Threat to Health or Safety:** Under Pennsylvania law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to

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take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

- **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Definitions

To help clarify the terms, here are some definitions:

- **"PHI" (Protected Health Information)** refers to information in your health record that could identify you.
- **"Treatment, Payment and Health Care Operations"** --Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of a disclosure related to treatment would be when I consult with another health care provider, such as your PCP or psychiatrist. --Payment is when I obtain reimbursement for your healthcare. Examples of disclosure for payment purposes are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. --Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. **NOTE:** In this office, my colleagues do not have access to my records and your records are kept in a locked filing cabinet.
- **"Use"** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"Disclosure"** applies to activities outside of my office, such as releasing, transferring or providing access to information about you to other parties.
- **"Consent"** is a general permission that allows me to use and disclose your health care information for routine purposes of treatment, payment and operations. For example, under the law, you must sign this consent form before I can begin to see you for therapy or provide other mental health services.
- **"Authorization"** is required by law and involves your written permission to use and disclose information not covered by the consent form. There are a few cases (see above) in which I am allowed, even required, to use and disclose your information without your consent or authorization. I will keep a record of disclosures, and this will be available to you.

IV. Patient's Rights and Provider's Duties:

- **Right to Request Restrictions**-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** -- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- **Right to an Accounting of Disclosures** - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process
- **Right to Inspect and Copy** - In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying

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and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

- **Right to Amend** - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

- **Right to a copy of this notice** - You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

SIGNATURE: _____ EFFECTIVE DATE: _____

Copy accepted by client Copy kept by therapist

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IMPORTANT INFORMATION REGARDING ISSUES OF CONFIDENTIALITY AND THE USE OF EMAIL AS A FORM OF COMMUNICATION

I, _____ understand that communicating with my therapist through email is NOT a confidential means of communication. Communicating through email has several risks. Which include, but are not limited to, the following:

- The email could fail to be received and that confidentiality could be breached
- An email could fail to be received if it is sent to the wrong email address or if it just is not noticed by the recipient
- Confidentiality could be breached in transit by hackers or internet service providers and at either end by others who had access to the account or the computer.

By signing below, I am stating that I understand that email is not confidential and I have been informed of the issues of confidentiality with email. Additionally, by signing below I am agreeing to release my rights to confidentiality when I communicate with my therapist through email.

Patient Signature

Date

Psychologist's signature

Date

Information You Have a Right to Know

When you come for therapy, you are buying a service to meet your individual needs. You need good information about therapy to make the best choice for yourself and your family. I have written down some questions you might want to ask me about how I do therapy. We may have talked about some of them already. You are free to ask me any of these questions, and I will try my best to answer them for you. If my answers are not clear, or if I have left something out, or if you have more questions, just ask me again. You have the right to full information about therapy.

A. About Therapy

1. What will we do in therapy?
2. What will I have to do in therapy?
3. Could anything bad happen because of therapy?
4. What will I notice when I am getting better?
5. About how long will it take for me to see that I am getting better?
6. Will I have to take any tests? What for? What kind?
7. How many (that is, what fraction) of your clients with my kind of problem get better?
8. How many (that is, what fraction) of your clients get worse?
9. How many (that is, what fraction) of people with the same kinds of problems I have get better without therapy? How many get worse?
10. About how long will therapy take?
11. What should I do if I feel therapy isn't working?

B. About Other Therapy and Help

1. What other types of therapy or help are there for my problems?
2. How often do these other methods help people with problems like mine?
3. What are the risks or limits of these other methods?

C. About Our Appointments

1. How will we set up our appointments?
2. How long will our sessions last? Do I have to pay more for longer ones?
3. How can I reach you in an emergency?
4. If I can't reach you, to whom can I talk?
5. What happens if the weather is bad or I'm sick and can't come to an appointment?

D. About Confidentiality

1. What kinds of records do you keep about my therapy?
2. Who is allowed to read these records?
3. Are there times you *have* to tell others about the personal things we might talk about?

E. About Money

1. What will you charge me for each appointment?
2. When do you want to be paid?
3. Do I need to pay for an appointment if I don't come to it, or if I call you and cancel it?
4. Do I need to pay for telephone calls to you?
5. Will you ever raise the fee that you charge me? When?
6. If I lose some of my income, can my fee be lowered?
7. If I do not pay my bill, what will you do?

F. Other Matters

1. How much training and experience do you have? Do you have a license? What are your other qualifications?
2. What kind of morals and values do you have?
3. To whom can I talk if I have a complaint about therapy that you and I can't work out?

The list above deals with the most commonly asked questions, but many people want to know more. Feel free to ask me any questions you have at any time. The more you know, the better our work will go. You can keep the "Information for Clients" brochure (if given) and this

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list. Please read them carefully at home, and if any questions come up, write them on this page so we can talk about them when we meet next time.

I, the client (or his or her parent or guardian), have gone over this list with the therapist, and I understand these questions and the therapist's answers.

Signature of client (or parent/guardian)

Date

Printed name

I, the therapist, have discussed these issues with the client (and/or his or her parent or guardian). I believe this person fully understands the issues, and I find no reason to believe that this person is not fully competent to give informed consent to treatment.

Signature of therapist

Date

Copy accepted by client Copy kept by therapist

What You Should Know about Confidentiality in Therapy

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the “confidentiality” of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a “secret” that I cannot keep secret. These are very important issues, so please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. When you or other persons are in physical danger, the law requires me to tell others about it. Specifically:

- a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
- b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
- c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
- d. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To “abuse” means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, if you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called “privilege,” and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

- a. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
- b. In cases where your emotional or mental condition is important information for a court's decision.
- c. During a malpractice case or an investigation of me or another therapist by a professional group.
- d. In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
- e. When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.

3. There are a few other things you must know about confidentiality and your treatment:

- a. I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.
- b. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

4. Here is what you need to know about confidentiality in regard to insurance and money matters:

- a. If you use your health insurance to pay a part of my fees, insurance companies require some information about our therapy. Insurers such as Blue Cross/Blue Shield or managed care organizations ask for much information about you and your symptoms, as well as a detailed treatment plan.
- b. I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information

Dr. April J. Perrymore
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about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information at the insurer's office. You cannot be required to release more information just to get payments.

c. If you have been sent to me by your employer's Employee Assistance Program, the program's staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.

d. If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

5. Children and families create some special confidentiality questions.

- a. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to *general* information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told. This is especially true if these others' actions put them or others in any danger.
- b. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.
- c. If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.
- d. If you and your spouse have a custody dispute, or a court custody hearing is coming up, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
- e. If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
- f. At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 7b, below.)

6. Confidentiality in group therapy is also a special situation.

In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.

7. Finally, here are a few other points:

- a. I will not record our therapy sessions on audiotape or videotape without your written permission.
- b. If you want me to send information about our therapy to someone else, you must sign a "release-of-records" form. I have copies you can see, so you will know what is involved.
- c. Any information that you also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally and to act in your best interests.

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

Signature of client (or person acting for client)

Date

Printed name

Signature of therapist

Date