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Confidentiality and Exceptions/Informed Consent

Welcome to my private practice. I firmly believe in my client's right to privacy. With few exceptions, information about you will be strictly confidential and will be released only when you have given your written permission. **Please read every portion of this document carefully and sign below indicating that you understand what you have read and agree.**

Due to legal and ethical restrictions, the only exceptions to strict confidentiality are:

1. If I suspect physical or sexual abuse, or neglect of a child.
2. If I suspect physical or sexual abuse, or neglect of an incapacitated adult.
3. If I am concerned that a client is in serious danger of harming himself/herself.
4. If I am concerned that a client is in serious danger of harming others.
5. If court-ordered, certain information may have to be released.
6. If you give written permission to release information to a specific person or organization.
7. If a medical emergency occurs while you are at my facility.

Informed Consent

Services provided by psychotherapy carry certain benefits, risks, and limits such as those described below:

BENEFITS: The benefits from counseling may be that thoughts and emotions which have interfered with your personal functioning and/or your relationships with others may be resolved or lessened, so that you will be better able to handle or cope with personal responsibilities and social relationships. Because of this, you may experience greater satisfaction from your daily life and interactions with others. Another possible benefit may be a better understanding of your own motives, values, and goals. This may lead to greater maturity and growth as a person.

RISK: Counseling may involve the risk of thinking about and/or disclosing unpleasant events, and can arouse intense feelings of anxiety, depression, frustration, loneliness, and helplessness.

MEDICAL LIMITS: This is not a crisis or emergency services clinic. **If you experience a crisis or emergency, please contact the Police Department or the emergency room for emergency services.** I am not a physician and cannot prescribe or provide you with medication, or perform any medical procedures. If medical treatment is indicated you may choose any physician whom you wish to see.

CONSULTATION/SUPERVISION: While information will not be released to outside persons or agencies without your permission, as professionals, my colleagues and I may confer with each other within our clinic. Each professional is bound by confidentiality according to the ethical codes of the American Counseling Association (ACA) and/or the American Psychological Association (APA).

TERMINATION/REFERRAL: Should it appear that my services may not or will not be appropriate for you, I will discuss this with you, will make appropriate referrals for you, and end services with you.

FEES/SCHEDULING: The fee for counseling services is \$100.00 per session. The sessions are one hour in duration and you must give 24 hours notice if you wish to cancel an appointment or the full per-session fee will be charged. It is my policy to charge interest on bills 30 days overdue and to hand over neglected bills to a collection agency or attorney.

I certify that I understand the contents of this document, and I give my consent for counseling services as described. I understand that I am ultimately responsible for my own health and wellness, and that if I require additional help or emergency assistance I will take appropriate measures, as described under **Medical Limits**, above:

_____ Date: _____